MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11416 — 11404 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 2 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 403 Joyce Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Glen Burnie
d. STREET ADDRESS: 403 Joyce Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Elizabeth — Last: Armiger
4. DATE OF DEATH: Month: Nov. — Day: 10 — Year: 1957

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec. 12, 1876
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jefferson M. Cook
14. MOTHER'S MAIDEN NAME: Emma Linstid

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: 6-------
17. INFORMANT: Wm. L. Armiger — Address: Riviera Beach, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute bronchopneumonia	4 days
331X DUE TO (b)	Cerebro-vascular accident	2 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	Arteriosclerotic cerebro-vascular disease	not determined

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 491X none

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 20, 1954, to November 10, 1957, that I last saw the deceased alive on November 9, 1957, and that death occurred at 10:44 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R. M. McLaughlin M.D. — ADDRESS (Street, city or town, state): Pasadena, Maryland — DATE SIGNED: Nov. 10, 1957

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov. 13, 57
22c. NAME OF CEMETERY OR CREMATORY: Mt. Carmel
22d. LOCATION (City, town, or county) (State): Anne Arundel, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: James C. Kirkley — ADDRESS: Hopping & Kirkley, Glen Burnie, Md.
24a. REC'D BY REGISTRAR DATE: NOV 13 1957
24b. REGISTRAR'S SIGNATURE: L. J. Dellabaugh

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11417 **CERTIFICATE OF DEATH**

Reg. Dist. No. 11405

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 38 years.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 113 First Avenue S.W.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Same — b. COUNTY: Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Same
d. STREET ADDRESS: Same
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Rosa — Middle: M. — Last: Arnold

4. DATE OF DEATH: Month: Nov. — Day: 20th. — Year: 19 1957

5. SEX: F.

6. COLOR OR RACE: W.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 11/11/66

9. AGE (In years last birthday): 91 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Woodville, Maryland.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joshua Hood

14. MOTHER'S MAIDEN NAME: Hannah Brashears

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mrs. Helen Kern (Daughter)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive Cardio Vascular Diseases. — 443X — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11/15/57, 19, to 11/20/57, 19, that I last saw the deceased alive on 11/19/57, 19, and that death occurred at 7 A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Gustave H Faubert M.D. — ADDRESS (Street, city or town, state): 5 First Avenue S.E. — DATE SIGNED: 11/21/57

PHYSICIAN'S NAME (Type): Gustave H. Faubert, M.D. — Glen Burnie, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11-23-1957

22c. NAME OF CEMETERY ~~OR CREMATORY~~: Prospect

22d. LOCATION (City, town, or county) (State): Frederick Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: C. M. Watts — ADDRESS: Winfield Md

24a. REC'D BY REGISTRAR DATE: NOV 25 1957

24b. REGISTRAR'S SIGNATURE: L. J. Bellamy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11418

CERTIFICATE OF DEATH

11406

Reg. Dist. No. 28

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville, Md.
c. LENGTH OF STAY IN 1b: 6 mo, 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 31 N. Bentalou Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First OAKLEY — Middle — Last BALL

4. DATE OF DEATH: Month 11 — Day 17 — Year 1957

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: Aug. 21, 1895

9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: ———

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Joe Ball

14. MOTHER'S MAIDEN NAME: Bertha

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): W. W. I

16. SOCIAL SECURITY NO.: ———

17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Insufficiency — INTERVAL BETWEEN ONSET AND DEATH
420.1
DUE TO
(b): Myocardial Fibrosis and Infarction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): Coronary Arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cerebral Hemorrhage

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): ———

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year ——— 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ———

20f. (City or town) (County) (State): ———

21. I certify that I attended the deceased from May 16, 19 57, to November 17, 19 57, that I last saw the deceased alive on November 17, 1957, and that death occurred at 11:05 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Ludwig Benedict M.D.
ADDRESS (Street, city or town, state): Crownsville, Md.
DATE SIGNED: 11/18/57

PHYSICIAN'S NAME (Type): Ludwig Benedict, M. D.
Crownsville State Hospital, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 11/22/57
22c. NAME OF CEMETERY OR CREMATORY: BALTIMORE NATIONAL
22d. LOCATION (City, town, or county) (State):

23. FUNERAL DIRECTOR'S SIGNATURE: Charles R Law
ADDRESS: 802 Madison Ave

24a. RECD BY REGISTRAR DATE: NOV 22 1957
24b. REGISTRAR'S SIGNATURE: Katherine Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

RECEIVED

NOV 22 1957

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11407

CERTIFICATE OF DEATH

11419

Reg. Dist. No. 24

1. PLACE OF DEATH

COUNTY Anne Arundel MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Glen Burnie

LENGTH OF STAY (in this place) 1 wk

HOSPITAL OR INSTITUTION OR STREET ADDRESS Sana Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Md COUNTY Anne Arundel

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Heights

STREET ADDRESS (If rural give location) 114 S. Camp Meade Rd.

3. NAME OF DECEASED (Type or Print) (First) AUGUST (Middle) F (Last) BECKER

4. DATE OF DEATH (Month) Nov (Day) 24 (Year) 1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
M	W	Wid.	Dec 23 1873	83 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Hardwood Finisher -		MD.	

13. FATHER'S NAME William Becker

14. MOTHER'S MAIDEN NAME UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No		705-03-5365	Nursing Home

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

332X IMMEDIATE CAUSE (A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 7 days

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Cerebral Thrombosis — 9 days

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
491X		YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ..... 19 54, to Nov 24, 1957, that I last saw the deceased alive on Nov 22, 1957, and that death occurred at 10:30 M, from the causes and on the date stated above.

SIGNATURE C. Milton Linthicum M.D. **ADDRESS** (Street, city, town, state) 106 W. Maple Rd Linthicum Hgts Md **DATE SIGNED** 11/24/57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	11-26-1957	Loudon Park	Baltimore Md.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
NOV 26 1957	L. J. Dalby	G. Howard Strong	3207 W North Ave.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11420 — Reg. Dist. No. 11408

1. PLACE OF DEATH
a. COUNTY: A. A. Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural
c. LENGTH OF STAY IN 1b: 15yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Earleigh Heights

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: A. A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Earleigh Heights
d. STREET ADDRESS: Severna-Park-Rt. 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Edna — Middle: Louise — Last: Bell
4. DATE OF DEATH: Month: Nov — Day: 30 — Year: 1957

5. SEX: F
6. COLOR OR RACE: Col.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-24-1901
9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months: ___ Days: ___
IF UNDER 24 HRS.: Hours: ___ Min: ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: ___
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Lewis W. Jeffries
14. MOTHER'S MAIDEN NAME: Annie B. Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT — Address: Charles W. Bell - Severna Park

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Chronic Myocarditis	18 mos
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Arteriosclerosis	3 yrs.
DUE TO (c)		

422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 260X Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov, 1953, to Nov 30, 1957, that I last saw the deceased alive on Nov 30, 1957, and that death occurred at 11:35 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Faye W. Allen M.D. — ADDRESS (Street, city or town, state): 62 Cathedral St Annapolis Md — DATE SIGNED: 12-2-57

PHYSICIAN'S NAME (Type): Faye W. Allen — 62 Cathedral St Annapolis Md 12-2-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-4-57
22c. NAME OF CEMETERY OR CREMATORY: Silas Baptists
22d. LOCATION (City, town, or county) (State): Earleigh-Heights Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Charles E. Hicks III — ADDRESS: Annapolis-Md
24a. REC'D BY REGISTRAR DATE: 12/3/57
24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1

Items 18 Film 222 11-15-57 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11409

CERTIFICATE OF DEATH

Reg. Dist. No. 78

11421

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville, Md.
c. LENGTH OF STAY IN 1b: 4 mo. 11 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BALTLO 3V01-4
d. STREET ADDRESS: 1837 N Castle St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Geneva; Middle: ; Last: Brady

4. DATE OF DEATH: Month: 11; Day: 1; Year: 19 57

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8/24/14

9. AGE (In years last birthday): 43 yrs.
IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: James Brady

14. MOTHER'S MAIDEN NAME: Mary Lewis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ----- (If yes, give war or dates of service): ----------

16. SOCIAL SECURITY NO.: ----------

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH:

352 X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Tetraplegia flaccid

DUE TO

(c) Fracture dislocation of 6th vertebra prior to — 3/4/54

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): D cubitus Ulcer

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.): ---------- ----------

20c. TIME OF INJURY: Hour a. m. p. m. ----- Month, Day, Year ----- 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ----------

20f. (City or town) (County) (State): ----------

21. I certify that I attended the deceased from June 21, 19 57 to November 1, 19 57 that I last saw the deceased alive on November 1, 19 57, and that death occurred at 5:40a. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp. M.D.

ADDRESS (Street, city or town, state): Crownsville, Md.

DATE SIGNED: 11/1/57

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D.

Crownsville State Hospital, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11/4/57

22c. NAME OF CEMETERY OR CREMATORY: Mt Auburn Cem

22d. LOCATION (City, town, or county) (State): Balto City

23. FUNERAL DIRECTOR'S SIGNATURE: Isaac L Rubenstein

ADDRESS: 105 W Monument St.

24a. REC'D BY REGISTRAR DATE: NOV 6 1957

24b. REGISTRAR'S SIGNATURE: R. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

RECEIVED

NOV 6 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11411

11392 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Burnside Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Annapolis
d. STREET ADDRESS: 1 Three Mile Oak
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROSE Middle EVA Last BRITTON
4. DATE OF DEATH: Month Nov Day 13 Year 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct. 26, 1892
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Annapolis, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel W. Smith
14. MOTHER'S MAIDEN NAME: Stella Brewer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 219-38-4948
17. INFORMANT: Mr Alfred W. Britton Sr.-Son- same as # 1 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Hrs
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cirrhosis of the liver
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept, 1955, to Nov 12, 1957, that I last saw the deceased alive on Nov 12, 1957, and that death occurred at 3 45 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: John A. Hedeman M.D.
ADDRESS (Street, city or town, state): 90 Cathedral Street, Annapolis, Md.
DATE SIGNED: 11/13/57
PHYSICIAN'S NAME (Type): JOHN HEDEMAN MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-16-57
22c. NAME OF CEMETERY OR CREMATORY: Cedar Bluff Cemetery
22d. LOCATION (City, town, or county) (State): Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Hopping Funeral Home
ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR DATE: NOV 18 1957
24b. REGISTRAR'S SIGNATURE: Wm. Grundy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11422 (Reg. Dist. No.) 11412

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenburnie
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 6118 Ritchie Highway

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Glenburnie
d. STREET ADDRESS: 6118 Ritchie Highway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FRANCES Middle M Last BROOKS

4. DATE OF DEATH: Month November Day 5 Year 1957

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

9. AGE (In years last birthday): 68 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland; Annie Arundel Co.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lawson Brooks

14. MOTHER'S MAIDEN NAME: Coronus Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Evelyn Riddick Address: 2207 Liberty Heights Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Massive Internal Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 30 hrs.

DUE TO (b): Gastric Ulcer — 3 weeks.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

540.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 15, 1956, to Nov. 4, 1957, that I last saw the deceased alive on Nov. 4, 1957, and that death occurred at 12:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: P. J. Grimaldi M.D. ADDRESS (Street, city or town, state): 4609 Gov. Ritchie Hwy DATE SIGNED:

PHYSICIAN'S NAME (Type): P. J. GRIMALDI

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Nov. 7, 1957

22c. NAME OF CEMETERY OR CREMATORY: Arbutus Memorial Park

22d. LOCATION (City, town, or county) (State): Arbutus, Annie Arundel Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Elroy O. Wilson ADDRESS: 1000 Brantley Avenue

24a. REC'D BY REGISTRAR DATE: NOV 12 1957

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SS

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11413

11393 **CERTIFICATE OF DEATH**

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 15 Baufum Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis 10
d. STREET ADDRESS 15 Baufum Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First John Middle W Last Brooks
4. DATE OF DEATH Month 11 Day 21 Year 1957

5. SEX Male
6. COLOR OR RACE Col.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 9-2-1890
9. AGE (In years last birthday) 67 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10b. KIND OF BUSINESS OR INDUSTRY Chauffeur
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME William H. Brooks
14. MOTHER'S MAIDEN NAME Fannie Brooks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address Dorthy Brooks - Annapolis, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Stomach — INTERVAL BETWEEN ONSET AND DEATH

151X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11-20-57, 19____ to 11-21-57, 19____, that I last saw the deceased alive on 11-21-57, 19____, and that death occurred at 11:50 M, from the causes and on the date stated above.

ACTUAL SIGNATURE [signature] M.D. ADDRESS (Street, city or town, state) 61 Cathedral St DATE SIGNED 11-22-57

PHYSICIAN'S NAME (Type) A T ALLEN La Annapolis Md

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 11-25-57
22c. NAME OF CEMETERY OR CREMATORY Carver Memorial
22d. LOCATION (City, town, or county) (State) Laurel, Md.

23. FUNERAL DIRECTOR'S SIGNATURE William Reese, Jr. ADDRESS Annapolis, Md.
24a. REC'D BY REGISTRAR DATE 11/29/57
24b. REGISTRAR'S SIGNATURE Thos J Hendrix

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11423 — 11414 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Broadwater Church
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Broad Water Church ton
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Guy — Middle: — Last: Brosee

4. DATE OF DEATH: NOVEMBER Day 2, Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MARCH 22, 1882

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months 7 Days 11 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - Govt. Printing Ofc. US Govt

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MAYSVILLE, KENTUCKY

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles E. Brosee

14. MOTHER'S MAIDEN NAME: Emma Newdigat

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: MRS. ROSE A. BROSEE - Broadwater, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Minutes

420.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteric sclerosis — 2+ years

DUE TO (c): Pulmonary Congestion — one week

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Pulmonary insufficency

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from December 1956 to November 1957, that I last saw the deceased alive on 2 November, 1957, and that death occurred at 8:15 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: F D Hendricks M.D. — ADDRESS (Street, city or town, state): Shady Side, Maryland — DATE SIGNED: 11/3/57

PHYSICIAN'S NAME (Type): F.D. Hendricks — Shady Side, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: NOV. 6/57

22c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CEM.

22d. LOCATION (City, town, or county) (State): SUITLAND, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: Martin W. Hysong Co. — ADDRESS: 1300-U St. N.W. Wash. D.C.

24a. REC'D BY REGISTRAR DATE: NOV 5 '57

24b. REGISTRAR'S SIGNATURE: A. Levin

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11424 (Anne Arundel)

CERTIFICATE OF DEATH

11415 58

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Crownsville, MD — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville, MD.

c. LENGTH OF STAY IN 1b: years

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Baltimore — b. COUNTY: MD. A. A.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XO Baltimore

d. STREET ADDRESS: 1. Box 417, Severna Park MD.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First (Eugene) Middle Thomas William Last Brown

4. DATE OF DEATH: Month 11 Day 10 Year 1957

5. SEX: male

6. COLOR OR RACE: C

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-13-1902

9. AGE (In years last birthday): 55 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: Designer

11. BIRTHPLACE (State or foreign country): Baltimore MD.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Eugene Brown.

14. MOTHER'S MAIDEN NAME: Della Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.

17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH
331X
DUE TO
(b): General arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): Cerebrovascular arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-26-, 1956, to 11-10 1957, that I last saw the deceased alive on ____, 19____, and that death occurred at 7:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): Crownsville State hospital — DATE SIGNED: 11/11/57

PHYSICIAN'S NAME (Type): L. Benedict MD. — Crownsville State hospital

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11-13-57

22c. NAME OF CEMETERY OR CREMATORY: St. Luke Cemetery

22d. LOCATION (City, town, or county) (State): Reisterstown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Charles R. Law 802 Madison Avenue

24d. RECD BY REGISTRAR DATE: NOV 14 1957

24b. REGISTRAR'S SIGNATURE: K. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11394

CERTIFICATE OF DEATH

11416 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, Annapolis, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Annapolis
d. STREET ADDRESS: Qtrs. A, Experimental Station
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Wheeler — Last: BROWN

4. DATE OF DEATH: Month: November — Day: 19 — Year: 19 57

5. SEX: M

6. COLOR OR RACE: Cau

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 17 July 1910

9. AGE (In years last birthday): 47 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Navy

10b. KIND OF BUSINESS OR INDUSTRY: U. S. Navy

11. BIRTHPLACE (State or foreign country): Tennessee

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Ralph W. Brown

14. MOTHER'S MAIDEN NAME: Belva McCallie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WWII & Korea

16. SOCIAL SECURITY NO.: 212-38-6694

17. INFORMANT — Address: U.S. Naval Hospital, Annapolis, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Thrombosis Cerebral middle cerebral artery — INTERVAL BETWEEN ONSET AND DEATH: 3½ days

332X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 15 November, 19 57, to 19 November, 19 57, that I last saw the deceased alive on 19 November, 19 57, and that death occurred at 0915 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas P. Connelly M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Annapolis, Md. — DATE SIGNED: 11-19-57

PHYSICIAN'S NAME (Type): T. P. CONNELLY CAPT MC USN

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal-Burial
22b. DATE THEREOF: 11/22/57
22c. NAME OF CEMETERY OR CREMATORY: Thmalpias Cemetery
22d. LOCATION (City, town, or county) (State): San Rafael California

23. FUNERAL DIRECTOR'S SIGNATURE: HOPPING FUNERAL HOME — ADDRESS: Annapolis, Maryland

24a. REC'D BY REGISTRAR DATE: 12 2 57

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11425

11417

Reg. Dist. No. 24

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PASADENA R.F.D.
c. LENGTH OF STAY IN 1b: # YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Rt. 9 Box. 101 WATERFORD ROAD

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): X2 PASADENA R.F.D.
d. STREET ADDRESS: Rt. 9, Box. 101 WATERFORD ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Lost	4. DATE OF DEATH Month	Day	Year
BARBARA	JOAN	BURWICK	NOVEMBER	10	1957

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
FEMALE	WHITE		Feb. 23, 1940	17 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student	High School	PENNINGTON GAP, VA.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
RAY BURWICK	CORDA WOODWARD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	----------	NONE	Mrs. Nell Wilson	Same as no. #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of the brain — INTERVAL BETWEEN ONSET AND DEATH: 6 months

193X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): none

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: R. M. McLaughlin M.D.
EXAMINER'S NAME (Type): R. M. McLaughlin
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: November 11, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Nov. 13, 1957	Cecil Cemetery	Pennington Gap, Va.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
R. V. Singleton	Glen Burnie, Md.	NOV 14 1957	L. J. Dellbaugh

TO DEMEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any de... necessary, please execute, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the f... director. Page 4 shou... forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be re... for your files. TO FUNDIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the St... Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11426 — 11418 — Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severna Park
c. LENGTH OF STAY IN 1b: 3 weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 115 Giddings Ave (Cape Arthur)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: New York
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn 69X-3
d. STREET ADDRESS: 747 41st Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MATTI — Middle — Last: CARLSON

4. DATE OF DEATH: Month: NOVEMBER — Day: 6 — Year: 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 8, 1889

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: General

11. BIRTHPLACE (State or foreign country): Findland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Paavo Carlson

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 051-09-2260

17. INFORMANT — Address: Mrs Anna Carlson - Wife - same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH:
420.1
DUE TO
(b): Coronary Heart Disease — 1 year
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Natural causes

20c. TIME OF INJURY — Hour: 2 p.m. — Month, Day, Year: 11-6- 19 57

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Severna Park, A.A., Maryland

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Francis I. Codd M.D. — DATE SIGNED

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): Francis I Codd MD — 11-7-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov. 9, 1957
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial Cemet.
22d. LOCATION (City, town, or county) (State): Annapolis, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Hopping Funeral Home Annapolis, Md.

24a. REC'D BY REGISTRAR — DATE: NOV 12 19

24b. REGISTRAR'S SIGNATURE

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11395 — 11419 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A.A. Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): A.A. General Hospital

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Md. — b. COUNTY: A.A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis, 10
d. STREET ADDRESS: 2 Dogwood Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EDWARD — Middle J. — Last CARPENTER
4. DATE OF DEATH: Month Nov. — Day 24 — Year 1957

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-26-1910
9. AGE (In years last birthday): 47 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PRINTER
10b. KIND OF BUSINESS OR INDUSTRY: Type Setter
11. BIRTHPLACE (State or foreign country): Mass.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: THOMAS CARPENTER
14. MOTHER'S MAIDEN NAME: Mary Fitzgerald

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WWII
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Mrs. Julia Carpenter #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 7 minutes
DUE TO (b): Coronary artery sclerosis, severe — 5 yrs.
DUE TO (c):

Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspectian ☐, Inquiry ☑, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: John L. Hardesman M.D.
EXAMINER'S NAME (Type)
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
DATE SIGNED: Nov. 24, 1957.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/29/57
22c. NAME OF CEMETERY OR CREMATORY: Oak Grove
22d. LOCATION (City, town, or county) (State): Rock Port Mass.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons
ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR DATE: 11/25/57
24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11420

11427

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bristol
c. LENGTH OF STAY IN 1b: 40 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deale Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X/ Bristol
d. STREET ADDRESS: / Deale Road
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Annie — Middle: Elizabeth — Last: Catterton

4. DATE OF DEATH: Month: Nov — Day: 19 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Mar. 12, 1884

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland.

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Joseph Griffith

14. MOTHER'S MAIDEN NAME: Mary Moreland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ----

16. SOCIAL SECURITY NO.: ----

17. INFORMANT: Address: Lillian M. Sherbert- Bristol, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 30 hrs.

442X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic CVR Disease — Unk

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year / Hour a. m. p. m. / 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 1946, to Nov 19, 1957, that I last saw the deceased alive on 18 Nov, 1957, and that death occurred at 8 30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: R R Sasscer M.D. ADDRESS (Street, city or town, state): Upper Marlboro Md DATE SIGNED: 19 Nov 57

PHYSICIAN'S NAME (Type): R. R. Sasscer, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11/21/57

22c. NAME OF CEMETERY OR CREMATORY: Mt. Zion Cemetery

22d. LOCATION (City, town, or county) (State): Lothian, Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Ritchie Bros Funeral Home-Marlboro, Md. Upper

24a. REC'D BY REGISTRAR: DATE NOV 25 57

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG223 12-12-57 et

CERTIFICATE OF DEATH

11396 — 11421 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A.A. County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: A.A. General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: A.A. County
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 106 South St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: — Last: Chambers

4. DATE OF DEATH: Month: 11 — Day: 30 — Year: 1957

5. SEX: Female
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 9-17-1904
9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Student
10b. KIND OF BUSINESS OR INDUSTRY: Maid
11. BIRTHPLACE (State or foreign country): Skidmore Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Chambers
14. MOTHER'S MAIDEN NAME: Irene Harris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): extensive inflammatory carcinoma left breast. — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b): Metastases to mediastinal, abd. lymphnodes — 10 months
DUE TO
(c): extreme obesity

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): hypertonia arteri

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-25, 1947, to 11-29, 1957, that I last saw the deceased alive on 11-28, 1957, and that death occurred at 11:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edith Rodler M.D. M.D. — ADDRESS (Street, city or town, state): 45 Franklin St. Annapolis Md. — DATE SIGNED: 12-3-57

PHYSICIAN'S NAME (Type): EDITH RODLER M.D. — 45 FRANKLIN ST. ANNAPOLIS Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-4-57
22c. NAME OF CEMETERY OR CREMATORY: Brewer Hill
22d. LOCATION (City, town, or county) (State): Annapolis, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Reed, A-Anna. Md. — ADDRESS
24a. REC'D BY REGISTRAR DATE: DEC 4 1957
24b. REGISTRAR'S SIGNATURE: Jm. French

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11397 — Reg. Dist. No. 11422

M

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 410 Second St.

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 1 410 Second St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Emmer — Middle: R. — Last: Chaney

4. DATE OF DEATH: Month: November — Day: 10 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 8, 1871

9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

I

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Annapolis, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert W. Brown

14. MOTHER'S MAIDEN NAME: Isabella Puckett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Daniel Chaney — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac disease — INTERVAL BETWEEN ONSET AND DEATH: Sudden
434.5
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: [signature] M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 11/1/57

EXAMINER'S NAME (Type): E. Linhardt

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-13-1957
22c. NAME OF CEMETERY OR CREMATORY: Cedar Bluff
22d. LOCATION (City, town, or county) (State): Annapolis Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor & Sons — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: 11/13/57

24b. REGISTRAR'S SIGNATURE: [signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11428

CERTIFICATE OF DEATH

11423

Reg. Dist. No.

1. PLACE OF DEATH
o. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Heights
c. LENGTH OF STAY IN 1b 5 years.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 209 - Poplar Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
o. STATE MARYLAND b. COUNTY Calvert
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelina 04X2.2
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First NANNIE-FLORINA Middle - Last COCHRANE

4. DATE OF DEATH Month 11 Day 16 Year 57 19

5. SEX F.
6. COLOR OR RACE W.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 12/15/79
9. AGE (In years last birthday) 78 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Calvert County, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME ? Williams
14. MOTHER'S MAIDEN NAME ? Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. No
17. INFORMANT Address Mrs. Margaret Lerouse (daughter)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Intestinal tract. — INTERVAL BETWEEN ONSET AND DEATH
153X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from — 19—, to — 19—, that I last saw the deceased alive on — 19—, and that death occurred at 7:30 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE Gustave H. Aubert M.D. ADDRESS (Street, city or town, state) Glen Burnie, Md. DATE SIGNED 11/16/57

PHYSICIAN'S NAME (Type) GUSTAVE-H.-AUBERT - M.D

22o. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 11-19-57
22c. NAME OF CEMETERY OR CREMATORY Mt Harmony
22d. LOCATION (City, town, or county) (State) Mt. Airy Md

23. FUNERAL DIRECTOR'S SIGNATURE Wm H. Hutchins ADDRESS Owings Md
24a. REC'D BY REGISTRAR DATE 11/18/57
24b. REGISTRAR'S SIGNATURE Grace L Hutchins C.R. Deputy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [redacted] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

RECEIVED

NOV 20 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11429 — Reg. Dist. No. 11424

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bar Harbor
c. LENGTH OF STAY IN 1b: 1 yrs.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 72 Johnson Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bar Harbor X2
d. STREET ADDRESS: 72 Johnson Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: ROSE — Middle: MARIE — Last: CROTHERS

4. DATE OF DEATH: Month: NOV. — Day: 3 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12/11/1886

9. AGE (In years last birthday): 70 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: at Home

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Henry Hessler

14. MOTHER'S MAIDEN NAME: Katherine Young

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ✓ (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: ✓

17. INFORMANT: Mr. William B. Crothers — Address: 72 Johnson Rd. Bar Harbor

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hypertensive Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 2 years

443X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 1, 1957 to Nov. 3, 1957 that I last saw the deceased alive on Nov. 1, 1957, and that death occurred at 5:20 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Brady Smith M.D. — ADDRESS (Street, city or town, state): Riviera Beach, Md. — DATE SIGNED: 11/3/57

PHYSICIAN'S NAME (Type): J. Brady Smith — Riviera Beach, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 11/6/57 — 22c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem. — 22d. LOCATION (City, town, or county) (State): 3801 Frederick Ave

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS

24a. REC'D BY REGISTRAR DATE: NOV 5 1957 — 24b. REGISTRAR'S SIGNATURE: L. J. Dalby

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/SS

1

Item 8, Film G222, 11/22/57 fcy

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11425

Reg. Dist. No. 21

11398

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 111 Granada Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 111 Granada Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HARRY — Middle W — Last DADDS

4. DATE OF DEATH: Month NOVEMBER — Day 13 — Year 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 15, 1889

9. AGE (In years last birthday): 68 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Plaster

10b. KIND OF BUSINESS OR INDUSTRY: Home Constructions

11. BIRTHPLACE (State or foreign country): Annapolis, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Dadds

14. MOTHER'S MAIDEN NAME: Christania Harold

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): nd

16. SOCIAL SECURITY NO.: 212-16-6740

17. INFORMANT: Mrs Pearl Dadds- Wife- same as # 2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 day
443X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Hypertensive cardio Vascular Disease — 1½ yrs
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 1, 1956, to Nov 13, 1957, that I last saw the deceased alive on 11-13-57, 19 57, and that death occurred at 12 30 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James R. Martin M.D. — ADDRESS (Street, city or town, state): 3 Shaw Street Annapolis, Md — DATE SIGNED: 11/14/57

PHYSICIAN'S NAME (Type): James R. Martin MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11-16-57

22c. NAME OF CEMETERY OR CREMATORY: Cedar Bluff Cemetery

22d. LOCATION (City, town, or county) (State): Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: [signature] — ADDRESS: HOPPING FUNERAL HOME Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: NOV 18 1957

24b. REGISTRAR'S SIGNATURE: Wm. J. Grinnalds

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11426

11399 **CERTIFICATE OF DEATH**

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lake Shore (Pasadena)
d. STREET ADDRESS: Rt 7 Box 402, Pasadena, Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ZEALON Middle BENJAMIN Last DAVENPORT

4. DATE OF DEATH: Month November Day 9, Year 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 28, 1898
9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lynotype operator
10b. KIND OF BUSINESS OR INDUSTRY: Commercial Printing
11. BIRTHPLACE (State or foreign country): N.C.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW I
16. SOCIAL SECURITY NO.: 139-05-6299
17. INFORMANT: Address: Mrs Mary A. Davenport- Wife- same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Pulmonary oedema	24 hours
DUE TO (b)	Cardiac decompensation	3 weeks
DUE TO (c)	Cardiac hypertrophy	unknown

4343

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 23, 1957, to Nov. 9, 1957, that I last saw the deceased alive on Nov. 9, 1957, and that death occurred at 9:30 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Arthur Lankford Jr M.D. — ADDRESS (Street, city or town, state): Mountain Rd. Pasadena Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): Arthur Lankford Jr. MD — Mt. Road, Pasadena, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 11-11-57
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Crematory
22d. LOCATION (City, town, or county) (State): Prince George County Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Hopping Funeral Home — ADDRESS: Annapolis, Maryland
24a. REC'D BY REGISTRAR DATE: NOV 12 1957
24b. REGISTRAR'S SIGNATURE: Wm. J. Grenchy

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11430 Items 11,12,13,14 FilmC223 11-29-57 et

11427 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY A. A. MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL

c. LENGTH OF STAY IN 1b ?

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) First Aid-Room

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3

d. STREET ADDRESS 3152-Alabama Rd.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First JOHN Middle D Last DEADWYLER

4. DATE OF DEATH Month Nov. Day 11 Year 1957

5. SEX M.

6. COLOR OR RACE C.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 12/20/09

9. AGE (In years last birthday) 48 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Commerce, Georgia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Deadwyler

14. MOTHER'S MAIDEN NAME Georgianna Deadwyler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY-OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH SUDDEN

420.1

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour ___ a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I taak charge of the remains described abave, held an Autopsy ☐, Inspectian ☒, Inquiry ☒, and in my apinian death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Gustave H Fanbert M.D. M.D.

EXAMINER'S NAME (Type) GUSTAVE-H. FAVBERT. M.D

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED 11/11/57

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF 11/16/57

22c. NAME OF CEMETERY OR CREMATORY Lincoln

22d. LOCATION (City, town, or county) (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE Robert G. Mason Funeral Home Inc ADDRESS O.E. Thomas (47)

24a. REC'D BY REGISTRAR DATE NOV 18 '57

24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11428

11431

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville, Md.
c. LENGTH OF STAY IN 1b: 3 mo.,21da.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3X01-4
d. STREET ADDRESS: 2021 Druid Hill Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: C. — Last: DeJonso

4. DATE OF DEATH: Month: 11 — Day: 14 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10/12/10

9. AGE (In years last birthday): 47 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffeur

10b. KIND OF BUSINESS OR INDUSTRY: ———

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Columbus DeJonso

14. MOTHER'S MAIDEN NAME: Gertrude Washington

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W. W. II

16. SOCIAL SECURITY NO.: 214-18-5484

17. INFORMANT — Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Terminal Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH

493X

DUE TO (b): Aspiration

Conditions, if ony, which gave rise to immediate couse (a), stoting the underlying cause last. — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cerebral Aneurysm. Post-operative Hemiplegia

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): ———

20c. TIME OF INJURY: Hour o. n. p. m. ——— Month, Day, Year ——— 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ———

20f. (City or town) (County) (State): ———

21. I certify that I attended the deceased from July 24, 1957, to November 14 1957, that I last saw the deceased alive an November 14, 1957, and that death occurred at 7:55 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Ludwig Benedict M.D. — ADDRESS (Street, city or town, state): Crownsville, Md. — DATE SIGNED: 11/15/57

PHYSICIAN'S NAME (Type): Ludwig Benedict, M. D. — Crownsville State Hospital, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 11-18-57

22c. NAME OF CEMETERY OR CREMATORY: BALTO. NAT'L CEMETERY

22d. LOCATION (City, town, or county) (State): BALTO. MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: Charles R. Lam — ADDRESS: 802 Madison Ave

24a. REC'D BY REGISTRAR — DATE: NOV 19 1957

24b. REGISTRAR'S SIGNATURE: R. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11432 (Reg. Dist. No.) 11429

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

1. PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md. b. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Beechwood Forest — c. LENGTH OF STAY IN 1b: 5 yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Beechwood Forest x2
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R.F.D. 3, Box 115 Pasadena Md	d. STREET ADDRESS: R.F.D. 3, Box 115 Pasadena — e. IS RESIDENCE ON A FARM? YES ☐ NO ☑
3. NAME OF DECEASED (Type or print): First M. Middle Helen Last Delaney	4. DATE OF DEATH: Month Nov Day 24 Year 1957
5. SEX: Female — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐ — 8. DATE OF BIRTH: 4/9/1868 — 9. AGE (In years last birthday): 89 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work — 10b. KIND OF BUSINESS OR INDUSTRY: at Home — 11. BIRTHPLACE (State or foreign country): Ireland — 12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME: Unknown — 14. MOTHER'S MAIDEN NAME: Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ✓ (If yes, give war or dates of service): ✓ — 16. SOCIAL SECURITY NO.: — — 17. INFORMANT: Mrs Frances Marion Barnes — Address: Rt 3, Box 115 Pasadena Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of the breast — INTERVAL BETWEEN ONSET AND DEATH: 3 years

DUE TO (b): Hypertensive, arteriosclerotic cardis- — 5 years

DUE TO (c): vascular disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 170X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): none

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from November 1, 1953, to November 24, 1957, that I last saw the deceased alive on November 23, 1957, and that death occurred at 4:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R. M. McLaughlin M.D. — ADDRESS (Street, city or town, state): Mountain Road Pasadena, Md. — DATE SIGNED: Nov 24 1957

PHYSICIAN'S NAME (Type): R. M. McLaughlin

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial	22b. DATE THEREOF: 11/27/57	22c. NAME OF CEMETERY OR CREMATORY: New Cathedral Cem.	22d. LOCATION (City, town, or county) (State): 4300 Old Frederick Rd.	
23. FUNERAL DIRECTOR'S SIGNATURE: John J. Cowan Son — ADDRESS: 99 Collins St.		24a. REC'D BY REGISTRAR DATE: NOV 27 1957	24b. REGISTRAR'S SIGNATURE: L J Dealey	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 6. See: Birth Cert. et

11433

CERTIFICATE OF DEATH

11430

Reg. Dist. No. 27

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ft Meade, Md
c. LENGTH OF STAY IN 1b: 1 da 14½ hrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Army Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1240 N. Curley Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 Vol-4

3. NAME OF DECEASED (Type or print): First MORRIS — Middle FRANK — Last DOZIER

4. DATE OF DEATH: Month November — Day 17 — Year 1957

5. SEX: Male

6. COLOR OR RACE: Negro Cau

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 15 Nov 57

9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months — Days 1
IF UNDER 24 HRS.: Hours 14½ — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frank NMI Dozier

14. MOTHER'S MAIDEN NAME: Helga G Wolf

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Nobe

17. INFORMANT — Address: Father, 1240 N. Curley St, Baltimore, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral damage due to septicemia and meningitis
768.0
DUE TO (b): meningitis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 1 day 14½ hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 16 Nov 57, to 17 Nov 57, that I last saw the deceased alive on 17 Nov 57, and that death occurred at 0255 AM, from the causes and on the date stated above.

0255 ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE: John L Robertson Capt MC M.D. USAH Ft George G Meade Md. 11 Dec 57

PHYSICIAN'S NAME (Type): JOHN L. ROBERTSON, Capt, MC

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11-20-57

22c. NAME OF CEMETERY OR CREMATORY: Baltimore National

22d. LOCATION (City, town, or county) (State)

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Earl Mobberly Funeral Home Inc 6306 Belair Rd Balto 6 Md.

24a. REC'D BY REGISTRAR DATE 18 Nov 57

24b. REGISTRAR'S SIGNATURE: Wilbur H. Downs, Jr. Capt. MSC

205025 IXV5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11431

11400 **CERTIFICATE OF DEATH**

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel Gen'l Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gambrills
d. STREET ADDRESS: Crain High Way
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Roger; Middle: Howard; Last: Drury

4. DATE OF DEATH: Month: November; Day: 15; Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 18, 1890

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic (ret.)

10b. KIND OF BUSINESS OR INDUSTRY: W.B.&A. R.R.Co.

11. BIRTHPLACE (State or foreign country): St. Mary'sCo., Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John W. Drury

14. MOTHER'S MAIDEN NAME: Mary V. Russell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mr. Roger H. Drury — Address: Gambrills, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease
DUE TO: with Congestive Failure
260X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c): Diabetes Mellitus with Gangrene of Feet

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-25-57 19____, to 11-15-57 19____, that I last saw the deceased alive on 10-15-57, 19____, and that death occurred at ____M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A. T. Allen M.D.

ADDRESS (Street, city or town, state): 62 Cathedral St

DATE SIGNED: 11-15-57

PHYSICIAN'S NAME (Type): A T ALLEN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Nov. 19, 1957

22c. NAME OF CEMETERY OR CREMATORY: Our Lady of the Field

22d. LOCATION (City, town, or county) (State): Millersville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Richard E. Singleton

ADDRESS: Glen Burnie, Md.

24a. REC'D BY REGISTRAR DATE: NOV 20 1957

24b. REGISTRAR'S SIGNATURE: Wm J. Francis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11434

11432

Reg. Dist. No. 24

1. PLACE OF DEATH

COUNTY ANNE ARUNDEL — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE

LENGTH OF STAY (in this place) 11yrs.

HOSPITAL OR INSTITUTION OR STREET ADDRESS 6720 Gov. Ritchie Hwy.

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE MARYLAND COUNTY ANNE ARUNDEL

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE

STREET ADDRESS (If rural give location) 6720 Gov. Ritchie Hwy.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
GABRIEL		ENSENAT	Nov.	2	1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	May 29, 1892	65 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Restaurenter	Self Emp 16yed	Spain	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Pete Ensenat	Medeline (Unknow)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No		220-22-3847	Mr. Pete Ensenat, Same as No. #2

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

156.1 IMMEDIATE CAUSE (A) Carcinoma of Liver & Metastasis — INTERVAL BETWEEN ONSET AND DEATH: 26 Oct 57

ANTECEDENT CAUSE(S) DUE TO (B) — to 2 Nov 57

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
9/30/57	Carcinoma of Liver & Metastasis	YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 26 Oct, 19 57, to 2 Nov, 19 57, that I last saw the deceased alive on 28 Oct, 19 57, and that death occurred at 2:15 P.M., from the causes and on the date stated above.

SIGNATURE AND TITLE OF M.D. A. D. Sommerville — ADDRESS (Street, city, town, state) 4016 Ritchie Hwy Baltimore Md — DATE SIGNED 4 Nov 57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Nov. 6, 57	Glen Haven Cemetery	Glen Burnie, Maryland

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
NOV 6 1957	L. J. Kelly	T. F. Singleton	Glen Burnie, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11435 (corrected) 11433 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY A.A. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 207 Cresswell Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn
d. STREET ADDRESS 207 Cresswell Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Middle Last: JOSEPH A. FELBINGER
4. DATE OF DEATH Month II/7/57 Day Year 19

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: IO/2I/87
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shoemaker
10b. KIND OF BUSINESS OR INDUSTRY: Dixie-Bartlett
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Andrew
14. MOTHER'S MAIDEN NAME: Anna ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address: Family - Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Caranoma, Metastatic	6 mos
DUE TO (b)	Caranoma Lung	1 year
DUE TO (c)		

163 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 16, 1956, to Nov 7, 1957, that I last saw the deceased alive on Nov 7, 1957, and that death occurred at 3 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Benjamin Berdann M.D. ADDRESS (Street, city or town, state): 5010A Reisterstown Baltimore 15 DATE SIGNED: Nov 8 57
PHYSICIAN'S NAME (Type): BENJAMIN BERDANN

22a. BURIAL, CREMATION, REMOVAL (Specify): B
22b. DATE THEREOF: II/II/57
22c. NAME OF CEMETERY OR CREMATORY: St. Mathews
22d. LOCATION (City, town, or county) (State): Baltimore

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: McCully Funeral Homes - I30 E. Fort Avenue
24a. REC'D BY REGISTRAR DATE: NOV 12 1957
24b. REGISTRAR'S SIGNATURE: Ida Whitson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11436 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 11434

Items 8,9 FilmG222 11-13-57 et

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Georgetown Near
c. LENGTH OF STAY IN 1b Jessup 1/2
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Md b. COUNTY Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Georgetown Near Jessup
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First BENJAMIN Middle Last GAITHER
4. DATE OF DEATH Month Nov Day 2nd Year 1957

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Colored		Mar 12 1892	64 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	B+O Railroad	Md	

13. FATHER'S NAME Dolly Gaither
14. MOTHER'S MAIDEN NAME Mandy Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	[illegible]	Nora Gaither Jessup R.F.D

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 1 hr.

DUE TO (b) Hypertension 1 yr.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 481x Influenza.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE Frank E. Shipley, M.D. M.D. DATE SIGNED

EXAMINER'S NAME (Type) Frank E. Shipley

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Nov 6 1957	[illegible] Cem.	Anne Arundel Co Md

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Ridgely Selby	101 Front St Rest Laurel Md	NOV 5 1957	Clara Rawlings

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11437

CERTIFICATE OF DEATH

11435 58

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore City

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville, Md.

c. LENGTH OF STAY IN 1b: 5yrs,4mo,16da.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3V01-4

d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Crownsville State Hospital, Md.

d. STREET ADDRESS: 511 N. Arlington Ave.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ernest — Middle: Bernard — Last: Gaskins

4. DATE OF DEATH: Month: 11 — Day: 19 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9/2/1912

9. AGE (In years last birthday): 45 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Porter

10b. KIND OF BUSINESS OR INDUSTRY: ———

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Unknown ALFRED

14. MOTHER'S MAIDEN NAME: Hattie Woods

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unknown (If yes, give war or dates of service): ———

16. SOCIAL SECURITY NO.: ———

17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Insufficiency — INTERVAL BETWEEN ONSET AND DEATH

420.1

DUE TO (b): Diffuse Myocardial

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Fibrosis - Coronary Sclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Schizophrenic Reaction - Catatonic Type

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. ——— Month, Day, Year ——— 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ———

20f. (City or town) (County) (State): ———

21. I certify that I attended the deceased from 12/30, 19 51, to 11/19, 19 57, that I last saw the deceased alive on November 19, 1957, and that death occurred at 5:30 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Ludwig Benedict M.D. — ADDRESS (Street, city or town, state): Crownsville, Md. — DATE SIGNED: 11/19/57

PHYSICIAN'S NAME (Type): Ludwig Benedict, M. D. — Crownsville State Hospital, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11-22-57

22c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary

22d. LOCATION (City, town, or county) (State): Annapolis, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Samuel W. Sullivan Jr. — ADDRESS: Balto

24a. REC'D BY REGISTRAR DATE: NOV 21 1957

24b. REGISTRAR'S SIGNATURE: A. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11438

CERTIFICATE OF DEATH

11436

Reg. Dist. No. 25

1. PLACE OF DEATH
a. COUNTY: A.A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn
c. LENGTH OF STAY IN 1b: 50
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 202 Arden Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn
d. STREET ADDRESS: 202 Arden Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First SOPHIA Middle Last GATES

4. DATE OF DEATH: Month II/II Day 57 Year 19

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/2/96

9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Leopold Krimmelbein

14. MOTHER'S MAIDEN NAME: Theodora Schultz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Family - Same — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Adeno-carcinoma of ovaries — INTERVAL BETWEEN ONSET AND DEATH: About 5 yrs.

175x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Metastatic carcinoma of Lungs — 1 yr.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertension & arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 1955 to Nov. 1957, that I last saw the deceased alive on Nov. 1957, and that death occurred at 3 p. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: John V. Szczerbicki M.D. — ADDRESS (Street, city or town, state): 1802 Eastern Ave — DATE SIGNED

PHYSICIAN'S NAME (Type): John V. Szczerbicki

22a. BURIAL, CREMATION, REMOVAL (Specify): B

22b. DATE THEREOF: II/I4/57

22c. NAME OF CEMETERY OR CREMATORY: Meadowridge

22d. LOCATION (City, town, or county) (State): Baltimore

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: McCully Funeral Homes - I30 E. Fort Avenue

24a. REC'D BY REGISTRAR DATE: NOV 14 1957

24b. REGISTRAR'S SIGNATURE: Ida Thulson

B

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11438

11401

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ANNE ARUNDEL GENERAL Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: A.A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 ANNAPOLIS
d. STREET ADDRESS: 1 RANDALL PLACE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: GEORGE — Middle: LEWIS — Last: HARDESTY

4. DATE OF DEATH: Month: 11 — Day: 4 — Year: 1957

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 9/19/1877

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): POSTMASTER
10b. KIND OF BUSINESS OR INDUSTRY: CIVIL SERVICE
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: WILLIAM ESTED HARDESTY
14. MOTHER'S MAIDEN NAME: MARTHA ELLEN CHANEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: MAE L. HARDESTY — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 331x Cerebral vascular accident
DUE TO
(b): generalized arteriosclerosis
DUE TO
(c): Parkinsonis disease, dementia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April, 1957, to Nov. 4, 1957, that I last saw the deceased alive on Nov. 4, 1957, and that death occurred at 4:05 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Emily H. Wilson M.D. — ADDRESS (Street, city or town, state): Crittenden, Md. — DATE SIGNED: 11-6-57

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 11/6/57
22c. NAME OF CEMETERY OR CREMATORY: St. JAMES
22d. LOCATION (City, town, or county) (State): TRACEY'S MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor & Sons — ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR DATE: 11/7/57
24b. REGISTRAR'S SIGNATURE:

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11402

CERTIFICATE OF DEATH

11439

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: A. A County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): A.A. General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: A.A. County
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Brooklyn Park
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Lera — Middle: Harold — Last:

4. DATE OF DEATH: Month: 11 — Day: 16 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: 8-13-1892

9. AGE (In years last birthday): 65 yrs. — IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Josiah Stansbury

14. MOTHER'S MAIDEN NAME: Jemima Chambers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Edward Harold - Anna, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebro-vascular accident — INTERVAL BETWEEN ONSET AND DEATH

331X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, a. m. / p. m., Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11-15-57, 19__ to 11-16-57, 19__, that I last saw the deceased alive on 11-16-57, 19__, and that death occurred at 6:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: A. T. Allen — M.D. — ADDRESS (Street, city or town, state): 62 Cathedral St — DATE SIGNED: 11-17-57

PHYSICIAN'S NAME (Type): A. T. ALLEN — Autopsy Ord

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 11-20-57 — 22c. NAME OF CEMETERY OR CREMATORY: Brad Neck — 22d. LOCATION (City, town, or county) (State): Skidmore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese — ADDRESS: #108 West St Annapolis

24a. REC'D BY REGISTRAR — DATE: 11/19/57 — 24b. REGISTRAR'S SIGNATURE: Wm. J. Trendy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11439 **CERTIFICATE OF DEATH** Reg. Dist. No. 11440

1. PLACE OF DEATH
a. COUNTY A. A. County MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton Md.
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION A. A. General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton Maryland x2
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Frank Middle S. Last Harrison
4. DATE OF DEATH Month 11 Day 24 Year 1957
5. SEX Male
6. COLOR OR RACE Colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 3-1-1895
9. AGE (In years last birthday) 62 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Odenton Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Richard Harrison
14. MOTHER'S MAIDEN NAME Josephine White
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 220-03-6635
17. INFORMANT Margarett Harrison Address Odenton Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro - vascular accident — INTERVAL BETWEEN ONSET AND DEATH
331X
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last. (b)
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11-22-57 19 to 11-24-57 19 that I last saw the deceased alive on 11-24-57 19, and that death occurred at 7:45 M, from the causes and on the date stated above.

ACTUAL SIGNATURE A. T. Allen M.D. ADDRESS (Street, city or town, state) A. A. County Md DATE SIGNED 11-26-57

PHYSICIAN'S NAME (Type) A T ALLEN Annapolis Md

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 11-28-57
22c. NAME OF CEMETERY OR CREMATORY Hanbes
22d. LOCATION (City, town, or county) (State) Odenton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE William Reese ADDRESS Anna. Md.
24a. REC'D BY REGISTRAR DATE 11/26/57
24b. REGISTRAR'S SIGNATURE Clara Hadaway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11441

CERTIFICATE OF DEATH

11440

Reg. Dist. No. 24

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH

COUNTY: Anne Arundel — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ferndale

LENGTH OF STAY (in this place): 27 yrs.

HOSPITAL OR INSTITUTION OR STREET ADDRESS: #104 Hollins Ferry Road

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland COUNTY: Anne Arundel

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): xo Ferndale, Glen Burnie P.O.

STREET ADDRESS (If rural give location): #104 Hollins Ferry Road

3. NAME OF DECEASED (Type or Print): Mary (First) Frances (Middle) Hartley (Last)

4. DATE OF DEATH: Nov. 13, 1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widow	Nov. 2, 1877	80 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework	Own Home	Fairfax Co., Virginia	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George T. Hughes	Florence Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
no	///////	none	303 Orchard Rd. Mr. Carroll Cook Ferndale, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 IMMEDIATE CAUSE (A): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSE(S) DUE TO (B):

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C):

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19e. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21e. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1951, 19..., to Nov. 13, 1957, that I last saw the deceased alive on Nov. 11, 1957, and that death occurred at 10:00 A.M. from the causes and on the date stated above.

SIGNATURE: C. Milton Linthicum M.D. — ADDRESS (Street, city, town, state): Linthicum Hghts., Md. — DATE SIGNED: Nov. 14/57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Nov. 16/57	Loudon Park Cem.	Baltimore, Maryland

24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
DATE NOV 18 1957	L. J. Dealba	P. J. Singleton	Glen Burnie, Md.

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V8, A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11441

11442

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Owings
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XO Owings
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First EVERETT — Middle — Last HAWKINS
4. DATE OF DEATH: Month 11/19 — Day — Year 57 19

5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct-21
9. AGE (In years last birthday): 14 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Fred Hawkins
14. MOTHER'S MAIDEN NAME: Helen Mackals

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — Address: Helen Hawkins Owings, md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple Traumatic Injuries
813X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto-bike collision
20c. TIME OF INJURY: Hour o. m. p. m. 11/19 Month, Day, Year 19 57
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street
20f. (City or town) Owings (County) Anne Arundel (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Partial, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: William V. Lovitt M.D.
EXAMINER'S NAME (Type): William V. Lovitt, Jr., M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: 11/20/57

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF: Nov-24-57
22c. NAME OF CEMETERY OR CREMATORY: Moses
22d. LOCATION (City, town, or county) (State): A.A. Co. md

23. FUNERAL DIRECTOR'S SIGNATURE: P. E. Sewell
ADDRESS: Prince Frederick, md
24a. REC'D BY REGISTRAR DATE: 11-25-57
24b. REGISTRAR'S SIGNATURE: H. W. Ward

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11443

11442 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY ANNE ARUNDEL. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DEALE, MD.
c. LENGTH OF STAY IN 1b LIFE
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION NONE

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD. b. COUNTY AA Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ DEALE
d. STREET ADDRESS NONE
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First ANNIE Middle FRANCES (NANNIE) Last HENLEY
4. DATE OF DEATH Month NOV. Day 2 Year 1957
5. SEX F
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 7/17/88
9. AGE (In years last birthday) 69 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) MD.
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME John Wm Phipps
14. MOTHER'S MAIDEN NAME Rispha Phipps

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address ELLA PHIPPS, DEALE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	GENERALIZED CARCINOMATOSIS.	5 YRS
170X DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO	CARCINOMA OF BREAST	15 YRS.
(c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/24, 1957, to 11/2, 1957, that I last saw the deceased alive on 10/30, 1957, and that death occurred at 7:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Richard N Peeler M.D. ADDRESS (Street, city or town, state) 68 Franklin St DATE SIGNED

PHYSICIAN'S NAME (Type) RICHARD N. PEELER Annapolis, Md. 11/2/57.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 11/5/57
22c. NAME OF CEMETERY OR CREMATORY St James
22d. LOCATION (City, town, or county) (State) Tracys Landing Md

23. FUNERAL DIRECTOR'S SIGNATURE Bernard Hardesty ADDRESS Galesville Md
24a. REC'D BY REGISTRAR DATE NOV 6 1957
24b. REGISTRAR'S SIGNATURE U. Council

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

RECEIVED

NOV 8 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11443

CERTIFICATE OF DEATH

11444 / 1

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville, Md.
c. LENGTH OF STAY IN 1b: 13ys,1mo,22da
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wayside, Md. 08X0.2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Loretta; Middle:; Last: Hill

4. DATE OF DEATH: Month: 11; Day: 9; Year: 1957

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Unknown

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: ———

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ———
(If yes, give war or dates of service): ———

16. SOCIAL SECURITY NO.: ———

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Congestion — INTERVAL BETWEEN ONSET AND DEATH:
519.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Pneumonia Pleural Effusion
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Convulsive Disorder

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): ———

20c. TIME OF INJURY: Hour a. m. p. m. ——— Month, Day, Year ——— 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ———

20f. (City or town) (County) (State): ———

21. I certify that I attended the deceased from September 18 1944, to November 9, 1957, that I last saw the deceased alive on November 9, 1957, and that death occurred at 11:45 a.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D.
ADDRESS (Street, city or town, state): Crownsville, Md.
DATE SIGNED: 11/12/57

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D.
Crownsville State Hospital, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/14/57
22c. NAME OF CEMETERY OR CREMATORY: Vet. Med. School
22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese
ADDRESS: 108 Main St. Annap. Md.

24a. REC'D BY REGISTRAR DATE: 11/18/57

24b. REGISTRAR'S SIGNATURE: F. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

RECEIVED

NOV 19 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11445

11403

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 9 Martin Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 9 Martin Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JULIA Middle ELIZABETH Last HOBAN

4. DATE OF DEATH: Month NOVEMBER Day 18 Year 19 57

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept 27, 1878
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): never worked
10b. KIND OF BUSINESS OR INDUSTRY: never worked
11. BIRTHPLACE (State or foreign country): Annapolis, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Patrick Hoban
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT Address: Mr. Charles Hoban - Nephew - same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma-Sepsis — INTERVAL BETWEEN ONSET AND DEATH: 1 month
DUE TO
(b): Carcinoma of finger — 2 yrs.
DUE TO
(c):

199.9
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-10-54, to 11-18-57, that I last saw the deceased alive on 11-18-57, and that death occurred at 6.30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James R. Martin M.D.
ADDRESS (Street, city or town, state): 6 Shaw Street, Annapolis, Md.
DATE SIGNED
PHYSICIAN'S NAME (Type): James R. Martin MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-21-57
22c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery
22d. LOCATION (City, town, or county) (State): Annapolis, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Hopping Funeral Home Annapolis, Md.
24a. REC'D BY REGISTRAR DATE: NOV 22 1957
24b. REGISTRAR'S SIGNATURE: Dr. French

E 7

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11404

CERTIFICATE OF DEATH

11446 21

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page 3 [illegible] be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 [illegible] 2 should be filed with the regis[illegible] prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: a a — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: a. a. General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: md
b. COUNTY: a a
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Galesville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Jessie Middle May Last Hopkins
4. DATE OF DEATH: Month 11 Day 22 Year 1957
5. SEX: Female
6. COLOR OR RACE: Colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6/10/78
9. AGE (In years last birthday): 79 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Cumberstone Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Robert Smith Hunt
14. MOTHER'S MAIDEN NAME: Rebecca F. Peake
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Miss Louise Woodfield Address: Galesville Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 – 3 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Generalized infection, site undetermined — 4 mos.
DUE TO
(c):
ICD: 053.4
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Blood dyscrasia, a/u. Metastatic cancer liver
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
491X
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1950, 19____, to 11-22-57, 19____, that I last saw the deceased alive on 11-22-57, 19____, and that death occurred at 10 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank M Shipley M.D. ADDRESS (Street, city or town, state): 63 College Ave DATE SIGNED: 11.23.57
PHYSICIAN'S NAME (Type): Frank M. Shipley Annapolis, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/24/57
22c. NAME OF CEMETERY OR ~~CREMATORY~~: Tracker
22d. LOCATION (City, town, or county) (State): Galesville Md

23. FUNERAL DIRECTOR'S SIGNATURE: Thomas Beardsley ADDRESS: Galesville Md
24a. REC'D BY REGISTRAR DATE: DEC 2 1957
24b. REGISTRAR'S SIGNATURE: Wm. J. French

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11447

CERTIFICATE OF DEATH

11444

Reg. Dist. No. 24

1. PLACE OF DEATH

COUNTY ANNE ARUNDEL — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GREEN HAVEN

LENGTH OF STAY (in this place) 10 YEARS

HOSPITAL OR INSTITUTION OR STREET ADDRESS 10 TH STREET

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE MARYLAND COUNTY ANNE ARUNDEL

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GREEN HAVEN

STREET ADDRESS (If rural give location) 10 TH STREET

3. NAME OF DECEASED (Type or Print) (First) LURA (Middle) VESTA (Last) HORSEMAN

4. DATE OF DEATH (Month) NOV. (Day) 30 (Year) 19 57

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
FEMALE	WHITE		AUG. 15, 1891	66 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	HOME	CAMBRIDGE MARYLAND	USA

13. FATHER'S NAME JAMES M. HIGGINS

14. MOTHER'S MAIDEN NAME DELLA LARRIMORE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 217-03-0836

17. INFORMANT & ADDRESS JAMES G. HORSEMAN - SAME

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

156.1 IMMEDIATE CAUSE (A) CARCINOMA LIVER — INTERVAL BETWEEN ONSET AND DEATH: 2 YEARS

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE — 2 YEARS

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from MAY, 19 56, to NOV. 30, 19 57, that I last saw the deceased alive on NOV. 29, 19 57, and that death occurred at 5:00 P.M., from the causes and on the date stated above.

SIGNATURE G. Brady Smith M.D. **ADDRESS** (Street, city, town, state) RIVIERA BEACH MD. **DATE SIGNED** 11/30/57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
B	12-4-57	Glen Haven	Balto.

24. REC'D BY REGISTRAR DATE DEC 2 1957

REGISTRAR'S SIGNATURE L Y Dedlbay

25. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Home ADDRESS

[redacted]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11448

.11445 **CERTIFICATE OF DEATH**

Reg. Dist. No. 27

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort George G. Meade
c. LENGTH OF STAY IN 1b: 19 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Army Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 1816 Patton Drive
d. STREET ADDRESS: Fort G. G. Meade
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GEORGE — Middle — — Last HUBBS

4. DATE OF DEATH: Month November — Day 19 — Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11 November 1889

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR — Months — Days
IF UNDER 24 HRS. — Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Soldier

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: David Hubbs

14. MOTHER'S MAIDEN NAME: Isabell Fisher

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
If yes, give war or dates of service:

16. SOCIAL SECURITY NO.: 189-16-1580

17. INFORMANT — Address: Daughter, 1816 Patton Drive, Fort Meade, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Embolus — INTERVAL BETWEEN ONSET AND DEATH: Immediate
332X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Basilar Artery Thrombosis — 19 Days
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1 Nov, 1957, to 19 Nov, 1957, that I last saw the deceased alive on 19 Nov, 1957, and that death occurred at 5:15 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: John L Robertson M.D. — ADDRESS (Street, city or town, state): USAH, Ft G. G. Meade, Md. — DATE SIGNED: 19 Nov 57

PHYSICIAN'S NAME (Type): JOHN L. ROBERTSON, Capt, MC

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Nov 25, 1957

22c. NAME OF CEMETERY OR CREMATORY: U. S. National Cemetery

22d. LOCATION (City, town, or county) (State): Beverley, New Jersey

23. FUNERAL DIRECTOR'S SIGNATURE: Ralph E. Hicks — ADDRESS: Elkton, Md

24a. REC'D BY REGISTRAR — DATE: 20 Nov 57

24b. REGISTRAR'S SIGNATURE: Wilbur H. Downs, Jr. Capt. MSC

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11446 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 11449

Reg. Dist. No. 24

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 2/57

1. PLACE OF DEATH
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jones Station, Severna Park
   c. LENGTH OF STAY IN 1b: 24 hrs.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Round Up Motel, Ritchie Highway

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3V01.4 ✓
   d. STREET ADDRESS: 1501 Ramsey Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John P. Inglassia Middle: Last: INGRASSIA

4. DATE OF DEATH: Month: Nov. Day: 25th. Year: 1957 19

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/3/08

9. AGE (In years last birthday): 49 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Burner

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): New York, N.Y.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank Inglassia

14. MOTHER'S MAIDEN NAME: Josephine LaGranda

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 11 world War

16. SOCIAL SECURITY NO.: 219-07-4788

17. INFORMANT — Address: Mr. Joseph Inglassia, (brother)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gustave H Faubert M.D. — DATE SIGNED

EXAMINER'S NAME (Type): Gustave H. Faubert, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒ 11/25/57

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 29 Nov 1957

22c. NAME OF CEMETERY OR CREMATORY: Holy Cross

22d. LOCATION (City, town, or county) (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: Rossi & B. M. Walters — ADDRESS: Pratt & Stricker Sts

24a. REC'D BY REGISTRAR — DATE: NOV 29 19

24b. REGISTRAR'S SIGNATURE: L. J. Dudley

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11447 **CERTIFICATE OF DEATH** 11450

Reg. Dist. No. 28

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville, Md.
c. LENGTH OF STAY IN 1b: 8mos.15 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3V01-4
d. STREET ADDRESS: Unknown
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Robert — Middle — Last Jackson

4. DATE OF DEATH: Month 11 — Day 19 — Year 19 57

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ ? DIVORCED ☐

8. DATE OF BIRTH: Unknown

9. AGE (In years last birthday): 45? yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: ———

11. BIRTHPLACE (State or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ? (If yes, give war or dates of service): ?

16. SOCIAL SECURITY NO.: 213-07-5620

17. INFORMANT — Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH
023X
DUE TO
(b): Hypertensive Heart Disease
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause lost.
DUE TO
(c): Status Epilepticus. Late latent Syphilis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 491X Chronic Brain Disease associated with Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year ——— 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 4, 19 57, to November 19 19 57 that I last saw the deceased alive on November 19 19 57, and that death occurred at 7:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: L. Benedict M.D. — ADDRESS (Street, city or town, state): Crownsville, Md. — DATE SIGNED: 11/22/57

PHYSICIAN'S NAME (Type): L. Benedict, M. D. — Crownsville State Hospital, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 11/27/57

22c. NAME OF CEMETERY OR CREMATORY: Woodlawn Memorial Park

22d. LOCATION (City, town, or county) (State): Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: William Reese #1088 W. Washington St. Balto. Md.

24a. REC'D BY REGISTRAR DATE: 12/2/57

24b. REGISTRAR'S SIGNATURE: A. M. Jaggard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11405

Reg. Dist. No. 11451

1. PLACE OF DEATH
a. COUNTY: A. A. County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: A.A. General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 10 1/
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Ehrene — Middle: — Last: Jones

4. DATE OF DEATH: Month: 11 — Day: 5 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 7-3-1896

9. AGE (In years last birthday): 61 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Maid

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Johnson

14. MOTHER'S MAIDEN NAME: Susie Bettes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Susie Cook — Address: 1954 West Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH:

331X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11-6-57, 19____, to 11-6-57 19____, that I last saw the deceased alive on 11-6-57, 19____, and that death occurred at 10:45 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A. J. Allen M.D. — ADDRESS (Street, city or town, state): 61 Cathedral — DATE SIGNED: 11-11-57

PHYSICIAN'S NAME (Type): A J ALLEN — Annapolis Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11-10-1957

22c. NAME OF CEMETERY OR CREMATORY: Mt. Zion

22d. LOCATION (City, town, or county) (State): Chesterfield Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: William Reese #108 Wash St. Anna. Md.

24a. REC'D BY REGISTRAR — DATE: NOV 12 1957

24b. REGISTRAR'S SIGNATURE: Wm J Trench

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

: 11448 **CERTIFICATE OF DEATH** 11452

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Baltimore City

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville, Md.

c. LENGTH OF STAY IN 1b: 11yr,11mo,4da.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3V01-4

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital, Md.

d. STREET ADDRESS: 154 East Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John Middle Last Jones

4. DATE OF DEATH: Month November Day 5 Year 19 57

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/7/1890

9. AGE (In years last birthday): 67 yrs.

IF UNDER 1 YEAR: Months ____ Days ____ IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Harry Jones

14. MOTHER'S MAIDEN NAME: Mary Sand

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W. W. I

16. SOCIAL SECURITY NO.: ----------

17. INFORMANT Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac Failure, and Syphilis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b): Electrolyte Deficiency

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Post-operation for Carcinoma of Rectum — October, 1957

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Paranoid Condition

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year ------ 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from December 1, 1945, to November 5, 1957, that I last saw the deceased alive on November 5, 1957, and that death occurred at 9:00 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. ADDRESS (Street, city or town, state): Crownsville, Md. DATE SIGNED: 11/6/57

PHYSICIAN'S NAME (Type): L. Benedict, M. D. Crownsville State Hospital, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial 22b. DATE THEREOF: 11-15-57 22c. NAME OF CEMETERY OR CREMATORY: Crownsville, Md. 22d. LOCATION (City, town, or county) (State): Crownsville Md.

23. FUNERAL DIRECTOR'S SIGNATURE: [signature] ADDRESS: Crownsville State Hospital, Crownsville, Md.

24a. REC'D BY REGISTRAR DATE: 11/8/57 24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11449 **CERTIFICATE OF DEATH** Reg. Dist. No. 11453

1. PLACE OF DEATH
a. COUNTY Anne Arundel L. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manhattan Beach. c. LENGTH OF STAY IN 1b 5yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manhattan Beach.
d. STREET ADDRESS Severna Park Md
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First John Middle T. Last Kelley
4. DATE OF DEATH Month 11 Day 15 Year 1957
5. SEX M. 6. COLOR OR RACE W. 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Sept 18, 1865
9. AGE (In years last birthday) 92 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard.
10b. KIND OF BUSINESS OR INDUSTRY Odd man
11. BIRTHPLACE (State or foreign country) Glyndon Md.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Wm Kelley.
14. MOTHER'S MAIDEN NAME Mary J. Bowen.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 218-07-3671
17. INFORMANT Daughter Mrs. Brewer Address Manhattan Beach Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure. — INTERVAL BETWEEN ONSET AND DEATH
450.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis.
DUE TO (c) Senility.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 57, 19____, to Nov____, 19 57, that I last saw the deceased alive on Sept 15, 19 57, and that death occurred at 6 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE Robert R Hahn M.D. ADDRESS (Street, city or town, state) Severna Park Md DATE SIGNED 11-15-57
PHYSICIAN'S NAME (Type) R. HAHN Severna Park Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Nov. 18/57
22c. NAME OF CEMETERY OR CREMATORY Druid Ridge
22d. LOCATION (City, town, or county) (State) Pikesville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J.F. Eline & Sons, Reisterstown, Md.
24a. REC'D BY REGISTRAR DATE 11-15-57
24b. REGISTRAR'S SIGNATURE L. J. Dallas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11450 CERTIFICATE OF DEATH

Reg. Dist. No. 11454

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 4 months
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 306 W. Furnace Branch Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Glen Burnie,
d. STREET ADDRESS: 306 W. Furnace Branch Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Carroll — Middle: Jay — Last: Klob

4. DATE OF DEATH: Month: Nov. — Day: 29 — Year: 1957

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 29, 1957

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: 4 Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ---------

10b. KIND OF BUSINESS OR INDUSTRY: ---------

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Klob

14. MOTHER'S MAIDEN NAME: Margeret Redman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none

16. SOCIAL SECURITY NO.: -----

17. INFORMANT: William Klob, Address: same as 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia Secondary to Vomiting — INTERVAL BETWEEN ONSET AND DEATH: immediate
DUE TO
(b): Acute Epidemic Gastro enteritis — 4 days
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

571.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11/28/57, 19____, to 11/29/57, 19____, that I last saw the deceased alive on 11/29/57, 19____, and that death occurred at 2.30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Leonard H. Flax, M.D. M.D. — ADDRESS (Street, city or town, state): 113 7th ave Brooklyn Park — DATE SIGNED: 11/30/57

PHYSICIAN'S NAME (Type): Leonard H. Flax, M.D. 113 7th Ave., Baltimore 25, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec. 2, 1957
22c. NAME OF CEMETERY OR CREMATORY: Meadowridge
22d. LOCATION (City, town, or county) (State): Howard County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Hopping and Kirkley — ADDRESS: Glen Burnie, Md.

24a. REC'D BY REGISTRAR DATE: DEC 2 1957
24b. REGISTRAR'S SIGNATURE: K. J. Kelley

2049273 XV4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11451

CERTIFICATE OF DEATH

11455 74

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ferndale
c. LENGTH OF STAY IN 1b: 5 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 309 Orchard Road.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Same
b. COUNTY: Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Same
d. STREET ADDRESS: Same
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Mary E. Middle Lamb Last
4. DATE OF DEATH: Month November Day 26 Year 19 57

5. SEX: F.
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1/16/83
9. AGE (In years last birthday): 74 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore County, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Eliza Fisher
14. MOTHER'S MAIDEN NAME: Amelia Tracy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: Mrs. Grace Lawrence (Niece)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Hypertensive cardiovascular diseases. — INTERVAL BETWEEN ONSET AND DEATH: 5 y.
443X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 19 52 to 11/26/57, 19 ____, that I last saw the deceased alive on 11/25/57, 19 ____, and that death occurred at 11 A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Gustave H. Faubert M.D. — ADDRESS (Street, city or town, state): — DATE SIGNED: 11/26/57

PHYSICIAN'S NAME (Type): Gustave H. Faubert, M.D. — Glen Burnie, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/29/57
22c. NAME OF CEMETERY OR CREMATORY: Lorraine
22d. LOCATION (City, town, or county) (State): Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John T. Stansbury 6411 Windsor Mill
24a. REC'D BY REGISTRAR DATE: DEC 2 1957
24b. REGISTRAR'S SIGNATURE: L. J. Dallas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page 3 [illegible] be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SS

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12661

.11452 **CERTIFICATE OF DEATH**

Reg. Dist. No. 28

1. PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville, Md. c. LENGTH OF STAY IN 1b: 1yr,1mo,13da. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital, Md.	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland — b. COUNTY: Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3V01-4 d. STREET ADDRESS: 1526 W. Lanvale Street e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	Delia	Bryant	Langley		11	24	1957

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	Negro		5/16/1855	102 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	----------	Maryland	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Daniel Bryant	Catherine Bryant

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
--------	----------	----------	Hospital Record	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH

450.0

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Arteriosclerosis

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Generalized Arteriosclerosis — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year ------- 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from October 11, 1957, to November 24 1957 that I last saw the deceased alive an October 11, 1957, and that death occurred at 9:40a M, from the causes and an the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp. M.D. — ADDRESS (Street, city or town, state): Crownsville, Md. — DATE SIGNED: 11/25/57

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D. — Crownsville State Hospital, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
	12.4.57	U. of Md. Med. School	Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
William Reese #108 Nash. St. Annap. Md.		12/9/57	F. M. Joyce

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11453

11456 Reg. Dist. No.

74

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena R.F.D. Green Haven
c. LENGTH OF STAY IN 1b: 10 Yrs
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: East Shore Road@ Seventh Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena R.F.D. Green Haven X2
d. STREET ADDRESS: East Shore Road@ Seventh
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph Middle: J Last: Laudermilk

4. DATE OF DEATH: Month: November Day: 4 Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 1878

9. AGE (In years last birthday): 79 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer (Ret)

10b. KIND OF BUSINESS OR INDUSTRY: Self Emp.

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Allen Laudermilk

14. MOTHER'S MAIDEN NAME: Rose Ann (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ----------

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asian influenza — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(b): Arteriosclerotic Cardio-vascular disease — several years
DUE TO
(c):

481X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Paralysis agitans - several years -

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 15, 1954, to Nov. 4, 1957, that I last saw the deceased alive on Nov. 3, 1957, and that death occurred at 11:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R. M. McLaughlin M.D.
ADDRESS (Street, city or town, state): RFD 8 Box 442 Pasadena Md.
DATE SIGNED: Nov. 4, 1957

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov. 7, 1957
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cem.
22d. LOCATION (City, town, or county) (State): Brooklyn RFD Md.

23. FUNERAL DIRECTOR'S SIGNATURE: A. P. Singleton
ADDRESS: Glen Burnie Md

24a. REC'D BY REGISTRAR DATE: NOV 12 1957
24b. REGISTRAR'S SIGNATURE: T. J. Dealbay

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page 3 [illegible] be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11406

11457

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ×2 Annapolis
d. STREET ADDRESS: 1 Weems Creek
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First AMANDA Middle LEWIS Last

4. DATE OF DEATH: Month NOVEMBER Day 14 Year 19 57

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 21, 1888
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): house wife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Annapolis, Md.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thaddius T. Lockett
14. MOTHER'S MAIDEN NAME: Mary Ellen Britton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.:
17. INFORMANT: John L. Anderton- Son- same as # 2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Left ventricular failure due to — INTERVAL BETWEEN ONSET AND DEATH
411X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Aortic Stenosis — 10 y
DUE TO (c): rheumatic heart disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Gen. arteriosclerosis, nephrosclerosis
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-7, 19 53, to 11-14, 19 57, that I last saw the deceased alive on 11-14, 19 57, and that death occurred at 6:25 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edith Rodler M.D. — ADDRESS (Street, city or town, state): 45 Franklin St Annapolis — DATE SIGNED: 11-16-57

PHYSICIAN'S NAME (Type): Edith Rodler MD — 45 Franklin Street, Annapolis, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-18-57
22c. NAME OF CEMETERY OR CREMATORY: Cedar Bluff Cemetery
22d. LOCATION (City, town, or county) (State): Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Hopping Funeral Home — ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR DATE: NOV 19 1957
24b. REGISTRAR'S SIGNATURE: Wm. J. French

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page 3 [illegible] be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 [illegible] 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

11454

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11458

Reg. Dist. No. 24

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 2/57

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severna Park
c. LENGTH OF STAY IN 1b: 7 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Riverdale Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Same — b. COUNTY: Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X1 Same
d. STREET ADDRESS: Same
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First Sharron — Middle Lee — Last Lucas

4. DATE OF DEATH: Month Nov. — Day 23 — Year 1957

5. SEX: F — 6. COLOR OR RACE: W — 7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ] — 8. DATE OF BIRTH: 4/23/57 — 9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months 7, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Annapolis, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Vernon Lucas
14. MOTHER'S MAIDEN NAME: Esther C. Calhoun

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: No
17. INFORMANT: William V. Lucas (father) — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PURULENT OTITIS MEDIA - LEFT. — 391.2
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, a. m. / p. m., Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: R.S. Fisher M.D.
EXAMINER'S NAME (Type): R.S. FISHER
CHIEF MEDICAL EXAMINER [X] ASSISTANT MEDICAL EXAMINER [ ] DEPUTY MEDICAL EXAMINER [ ]
DATE SIGNED: 11/24/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/26/57
22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial
22d. LOCATION (City, town, or county) (State): Glen Burnie, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Hopping & Kirkley, — ADDRESS: Glen Burnie, Md.
24a. REC'D BY REGISTRAR DATE: NOV 29 1957
24b. REGISTRAR'S SIGNATURE: L.J. Dalby

20632 25 XV6

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11455 — 11459 — Reg. Dist. No. 24

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GLEN BURNIE
c. LENGTH OF STAY IN 1b: 23 YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): #112 FORREST RD., MARLEY PARK

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GLEN BURNIE, RFD, MARLEY PARK ×2
d. STREET ADDRESS: #112 FORREST RD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: PERRY — Middle: OLIVER — Last: MARSH

4. DATE OF DEATH: Month: NOVEMBER — Day: 1, — Year: 19 57

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: AUGUST 4, 1887

9. AGE (In years last birthday): 70 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LONGSHOREMAN (Ret.)

10b. KIND OF BUSINESS OR INDUSTRY: I.L.A., BALTO.

11. BIRTHPLACE (State or foreign country): BALTIMORE CO., MD.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: PERRY MARSH

14. MOTHER'S MAIDEN NAME: OCTAVIA BOWAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): //////

16. SOCIAL SECURITY NO.: UNKNOWN

17. INFORMANT: MRS. LOUISE SCHOOLMAN — Address: 113 Forrest Rd. Glen Burnie RFD, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Diabetes — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO
260×
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) General Arteriosclerosis — ?
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Gustave H Faubert M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED

EXAMINER'S NAME (Type): Gustave H. Faubert, M.D. — 11/3/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Nov-4/57 — 22c. NAME OF CEMETERY OR CREMATORY: St. James — 22d. LOCATION (City, town, or county) (State): My Lady's Manor Md

23. FUNERAL DIRECTOR'S SIGNATURE: Richard V. Seiglen — ADDRESS: Glen Burnie, Md. — 24a. REC'D BY REGISTRAR DATE: NOV 6 1957 — 24b. REGISTRAR'S SIGNATURE: L. J. Dalby

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11456 **CERTIFICATE OF DEATH** 11460

Reg. Dist. No. 7

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Odenton
c. LENGTH OF STAY IN 1b: 6Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Patuxent Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x/ Odenton
d. STREET ADDRESS: Patuxent Road
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First James — Middle M. — Last Martz Sr.

4. DATE OF DEATH: Month November — Day 4 — Year 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 30, 1864

9. AGE (In years last birthday): 92 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer (Ret)

10b. KIND OF BUSINESS OR INDUSTRY: Self Emp.

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George N. Martz

14. MOTHER'S MAIDEN NAME: Sarah (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: James M. Martz Jr. Patuxent Rd. Odenton

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.
422.1
DUE TO (b): Arteris-Sclerosis — 8-10 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Prostatitis & Cystitis & Pyelitis — 10 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan — 1949, to 11/4/57, 19____, that I last saw the deceased alive on 11/4/57, 19____, and that death occurred at 2:47 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Chas. L. Ball Jr. M.D. — ADDRESS (Street, city or town, state): Linthicum — DATE SIGNED: 11/6/57

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov. 7, 57
22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Cemetery
22d. LOCATION (City, town, or county) (State): Glen Burnie, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: Glen Burnie Md.

24a. REC'D BY REGISTRAR — Date: NOV 12 1957

24b. REGISTRAR'S SIGNATURE: Clara Fahlup

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55.

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11457

11461 34.

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena (Magothy Beach)
c. LENGTH OF STAY IN 1b: 2 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Box 179A Riverside Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Same — b. COUNTY: Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Same
d. STREET ADDRESS: Same
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Casper — Middle: Joseph — Last: Miller

4. DATE OF DEATH: Month: November — Day: 28th. — Year: 19 57

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12/15/04

9. AGE (In years last birthday): 52 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffeur

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Miller

14. MOTHER'S MAIDEN NAME: Theresa Slack

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 217-01-2077

17. INFORMANT: Address: Mrs. Rose Miller (wife)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 420.1 Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO
(b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gustave H. Faubert M.D. — DATE SIGNED

EXAMINER'S NAME (Type): Gustave H. Faubert M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒ — 11/28/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec. 2, 1957
22c. NAME OF CEMETERY OR CREMATORY: Sacred Heart of Jesus Cem.
22d. LOCATION (City, town, or county) (State): German Hill Road

23. FUNERAL DIRECTOR'S SIGNATURE: Raymond L. Kacyorowski — ADDRESS: 2525 Fleet St.

24a. REC'D BY REGISTRAR DATE: DEC 5 1957

24b. REGISTRAR'S SIGNATURE: L. J. Dalby

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11407

CERTIFICATE OF DEATH

11462

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Homewood Convalescent Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 158 Conduit St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Harry — Middle B. — Last Miller

4. DATE OF DEATH: Month November — Day 29 — Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: August 23 1870

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Postal Supervisor

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't.

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Adam Miller

14. MOTHER'S MAIDEN NAME: Jennie Lininger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): SPANISH

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Helen M. Hillman — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Heart failur — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs

422.1

DUE TO (b): Cerebrovascular cardiovascular disease — 20 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse lost.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1956, to Nov 29, 1957, that I last saw the deceased alive on Nov 26, 1957, and that death occurred at 12:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John L. Hedman M.D. — ADDRESS (Street, city or town, state): Annapolis Md. — DATE SIGNED: 11/29/57

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 12-3-57

22c. NAME OF CEMETERY OR CREMATORY: LAUREL MEMORIAL PK. — 22d. LOCATION (City, town, or county) (State): Atlantic City N.J.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS: Annapolis Md.

24a. REC'D BY REGISTRAR DATE: 12/2/57

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

RECEIVED

DEC 4 1937

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11463

CERTIFICATE OF DEATH

11408

Reg. Dist. No. 21

1. PLACE OF DEATH

COUNTY Anne Arundel — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Arundel General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY A.A.

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Churchton

STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) WILLIAM (Middle) FRANK (Last) MILLER

4. DATE OF DEATH (Month) Nov (Day) 18, (Year) 1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Widower	Nov 18, 1885	72 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Policeman	Met Police retired	New York	U.S.A

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
yes	Peace Time	unknown	William F. Miller Son 2209 Jamieson St. Hill Crest Hghts Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

491X IMMEDIATE CAUSE (A) Bronchopneumonia — 3 d.

ANTECEDENT CAUSE(S) DUE TO (B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Myocardial infarction — 2 wks

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-5-, 1957, to 11-18-, 1957, that I last saw the deceased alive on 11-18-, 1957, and that death occurred at 10 P.M, from the causes and on the date stated above.

SIGNATURE	ADDRESS (Street, city, town, state)	DATE SIGNED
Frank Underhill M.D.	63 College Ave. Annapolis Md	Nov 19, 57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	11-22-57	Cedar Hill Cem.	Suitland, Maryland

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
NOV 25 1957	Wm J French	W. W. Chambers Co.	Washington, D.C

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The box... copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11458 — Reg. Dist. No. 11464

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville, Md.
c. LENGTH OF STAY IN 1b: 6ys, 9mo, 19da.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 601 S. Paca Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alice; Middle: ; Last: Moody

4. DATE OF DEATH: Month: 11; Day: 24; Year: 19 57

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8/9/77

9. AGE (In years last birthday): 80 yrs. IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ———

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Landy Moody

14. MOTHER'S MAIDEN NAME: Anne Olivia Hardey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ——— (If yes, give war or dates of service): ———

16. SOCIAL SECURITY NO.: ———

17. INFORMANT: Hospital Record — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Insufficiency — INTERVAL BETWEEN ONSET AND DEATH:

420.1

DUE TO (b): Myocardial Infarction

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Arteriosclerotic -Cardiovascular Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senile Psychosis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): ———

20c. TIME OF INJURY: Hour a. m. p. m. ——— Month, Day, Year ——— 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ———

20f. (City or town) (County) (State): ———

21. I certify that I attended the deceased from January 5, 19 51, to November 24, 19 57, that I last saw the deceased alive on November 24, 19 57, and that death occurred at 1:30A. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D. — ADDRESS (Street, city or town, state): Crownsville, Md. — DATE SIGNED: 11/25/57

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D. — Crownsville State Hospital, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 11/27/57 — 22c. NAME OF CEMETERY OR CREMATORY: Mt Auburn — 22d. LOCATION (City, town, or county) (State): Baltimore Md

23. FUNERAL DIRECTOR'S SIGNATURE: Charles A. Price — ADDRESS: 661 W. Barre St

24a. REC'D BY REGISTRAR DATE: 11/29/57 — 24b. REGISTRAR'S SIGNATURE: A. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11459

CERTIFICATE OF DEATH

11465

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gambrills
c. LENGTH OF STAY IN 1b: 28 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crain Highway

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x/Gambrills
d. STREET ADDRESS: Crain Highway
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First TIMOTHY Middle A. Last O'KEEFE

4. DATE OF DEATH: Month Nov. Day 13, Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: Jan. 10/1876

9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer (ret.)

10b. KIND OF BUSINESS OR INDUSTRY: Self Employed

11. BIRTHPLACE (State or foreign country): Ireland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Michael O'Keefe

14. MOTHER'S MAIDEN NAME: Johanna Donovan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): ////////

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Mr. Louis O'Keefe — Address: Same As #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): General Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs. +
DUE TO
450.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from January, 1952, to Nov. 13, 1957, that I last saw the deceased alive on Nov. 8, 1957, and that death occurred at 2:A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Gustave H. Faubert M.D.
ADDRESS (Street, city or town, state): Glen Burnie, Maryland
DATE SIGNED: Nov. 14/57

PHYSICIAN'S NAME (Type): Gustave H. Faubert

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov. 15/57
22c. NAME OF CEMETERY OR CREMATORY: Our Lady of the Fields
22d. LOCATION (City, town, or county) (State): Millersville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] Singleton
ADDRESS: Glen Burnie, Md.

24a. REC'D BY REGISTRAR DATE: NOV 18 1957
24b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11460

CERTIFICATE OF DEATH

11466

Reg. Dist. No. 24

1. PLACE OF DEATH
a. COUNTY: Anna Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bar Harbor
c. LENGTH OF STAY IN 1b: 50 yrs
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Johnson Rd. Pasadena Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XO Baltimore 24
d. STREET ADDRESS: 524 S. Lakewood Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First THOMAS Middle KOLBJORN Last OLSEN

4. DATE OF DEATH: Month Nov. Day 3. Year 1957

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 25. 1888

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chief Mate, Merchant

10b. KIND OF BUSINESS OR INDUSTRY: Marine Retired 30Yrs.

11. BIRTHPLACE (State or foreign country): Norway

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Christian Olsen

14. MOTHER'S MAIDEN NAME: Andrea Knutsen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: John Olsen. Address: 524 S. Lakewood Ave. 24

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma Stomach — INTERVAL BETWEEN ONSET AND DEATH: 2 years
151X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 19, 1957, to 11/4, 1957, that I last saw the deceased alive on 11/2, 1957, and that death occurred at 12:17 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Brady Smith M.D. — ADDRESS (Street, city or town, state): Riviera Beach — DATE SIGNED: 11/5/57

PHYSICIAN'S NAME (Type): J. Brady Smith — Pasadena, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Nov. 7. 1957

22c. NAME OF CEMETERY OR CREMATORY: Moreland Mem. Park Cem.

22d. LOCATION (City, town, or county) (State): Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: HENRY SANDER & SONS. INC. Baltimore Md.

24a. REC'D BY REGISTRAR DATE: NOV 8 1957

24b. REGISTRAR'S SIGNATURE: L. J. Dellbay

Guy F. Hamler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

Item 6, Film G222, 11/22/57 fcy

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11461

11467

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater, c. LENGTH OF STAY IN 1b 7 weeks	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Edgewater,
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ~~at Home of~~ Rt 1 Box 273 C Selly on the Bay	d. STREET ADDRESS 1 Rt 1, Box 273 C Selly on the Bay; e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print)	First: David	Middle: —	Last: Park
4. DATE OF DEATH	Month: November	Day: 16	Year: 1957

5. SEX	Male
6. COLOR OR RACE	CHINESE ~~White~~
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐	
8. DATE OF BIRTH	Oct. 2, 1957
9. AGE (In years last birthday)	~~6 weeks~~ 1½ (Months)
IF UNDER 1 YEAR: Months / Days	
IF UNDER 24 HRS.: Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)	Washington, D.C
12. CITIZEN OF WHAT COUNTRY?	U.S.A.
13. FATHER'S NAME	Park, Chung Soo
14. MOTHER'S MAIDEN NAME	Lee, Bum Joon
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.	
17. INFORMANT / Address	Father 1701 Park Rd. N.W. Washington D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia — INTERVAL BETWEEN ONSET AND DEATH: 30 min?

925.0

DUE TO (b)

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Child was found ~~in~~ death in his crib by Mrs. Dempsey who is foster parent

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt 1 Box 273 C Edgewater

20f. (City or town) (County) A. A (State) Md

21. I certify that I attended the deceased from Nov. 16, 1957, to ________, 19__, that I last saw the deceased alive on ________, 19__, and that death occurred at 5:40 A.M, from the causes and on the date stated above.

ACTUAL SIGNATURE Sylvia M Lim M.D. ADDRESS (Street, city or town, state) Rt 1 Box 277-M Edgewater, Md. DATE SIGNED 11-16-57

PHYSICIAN'S NAME (Type) Sylvia M. Lim

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	11-16-57	Hillcrest Cemetery	Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
HOPPING FUNERAL HOME Annapolis, Md.	DATE NOV 18 1957	[signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11468

11409

CERTIFICATE OF DEATH

Reg. Dist. No. 78

1. PLACE OF DEATH
a. COUNTY Sarris Nursing Home Millersville A.A Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis md.
c. LENGTH OF STAY IN 1b 5 mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cecil Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Best Gate Rd. R F D. Annapolis Md.
d. STREET ADDRESS 103 Best Gate Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First Rose Middle E. Last Pindell
4. DATE OF DEATH Month Nov Day 9-57 Year 19

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH Sept-7-1901
9. AGE (In years last birthday) 56 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife.
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Lamb.
14. MOTHER'S MAIDEN NAME Carrie —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. None
17. INFORMANT Address Mrs. Dorothy Smith - Daughter same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Lobar Pneumonia — Interval between onset and death: 7 days
DUE TO (b) Cerebral Thrombosis — 4 months
DUE TO (c) Hemiplegia (left) Residuals — 3 months

490X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. ——— 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 5-57, 19—, to Nov 9-57 19—, that I last saw the deceased alive on Nov 5-57, 19—, and that death occurred at 5:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Joseph Lipskey M.D. ADDRESS (Street, city or town, state) Glenburnie Md DATE SIGNED 11-9-57

PHYSICIAN'S NAME (Type) JOSEPH LIPSKEY

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 11-12-57
22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemet.
22d. LOCATION (City, town, or county) (State) Glen Burnie, Md

23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home ADDRESS Annapolis, Md.
24a. REC'D BY REGISTRAR DATE NOV 12 1957
24b. REGISTRAR'S SIGNATURE H. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14 FilmG223 11-29-57 et

CERTIFICATE OF DEATH

11462 — Reg. Dist. No. 11469

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville, Md.
c. LENGTH OF STAY IN 1b: 3ys, 6mo, 11da.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 3113 Normount Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles; Middle: ; Last: Porter

4. DATE OF DEATH: Month: 11; Day: 18; Year: 19 57

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 4/6/1873

9. AGE (In years last birthday): 84 yrs. IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: ———

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ———

16. SOCIAL SECURITY NO.: ———

17. INFORMANT: Hospital Record — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH:

023X

DUE TO (b): Arteriosclerosis and Syphilis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic Brain Syndrome associated with Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): ———

20c. TIME OF INJURY: Hour o. m. p. m. ——— Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ———

20f. (City or town) (County) (State): ———

21. I certify that I attended the deceased from May 7, 1954, to November 18 1957, that I last saw the deceased alive on November 18, 1957, and that death occurred at 4:55 A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Ludwig Benedict M.D. — ADDRESS (Street, city or town, state): Crownsville, Md. — DATE SIGNED: 11/18/57

PHYSICIAN'S NAME (Type): Ludwig Benedict, M. D. — Crownsville State Hospital, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11-21-57

22c. NAME OF CEMETERY OR CREMATORY: mt evbown

22d. LOCATION (City, town, or county) (State): md

23. FUNERAL DIRECTOR'S SIGNATURE: Geo. E. Nelson — ADDRESS: 1348 N. Calhoun St.

24a. REC'D BY REGISTRAR DATE: NOV 25 1957

24b. REGISTRAR'S SIGNATURE: F. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11470

CERTIFICATE OF DEATH

11463

Reg. Dist. No. 78

1. PLACE OF DEATH

COUNTY Anne Arundel MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville

LENGTH OF STAY (in this place) 1 mo.

HOSPITAL OR INSTITUTION OR STREET ADDRESS Sann's Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Anne Arundel

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ~~Millers~~ Glen Burnie

STREET ADDRESS (If rural give location) 401 Furnace Branch Road

3. NAME OF DECEASED (Type or Print) (First) William (Middle) A (Last) Purkins

4. DATE OF DEATH (Month) 11 (Day) 7 (Year) 1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Oct. 28-1884	73 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photo Engraver (ret.)

10b. KIND OF BUSINESS OR INDUSTRY Publicity Eng. Co.

11. BIRTHPLACE (State or foreign country) Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George M. Purkins

14. MOTHER'S MAIDEN NAME Mary Heiderman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service) — — — — —

16. SOCIAL SECURITY NO. Unknown

17. INFORMANT & ADDRESS Mrs. Vesta E. Purkins Same as No. #2

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

1443X IMMEDIATE CAUSE (A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSE(S) DUE TO (B) Hypertensive Cardio-Vascular Dis.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-30, 1957, to 11-6, 1957, that I last saw the deceased alive on 11-6, 1957, and that death occurred at 12:30 P.M., from the causes and on the date stated above.

SIGNATURE C. R. MacDonald M.D. M.D. ADDRESS (Street, city, town, state) Glen Burnie Md DATE SIGNED 11-8-57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Nov. 11-1957	Glen Haven Cemetery	Glen Burnie, Maryland

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
NOV 12 1957	J. M. Joyce	H. L. Singleton	Glen Burnie, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

114!1 — Reg. Dist. No. 11471

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): A.A. GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS 10
d. STREET ADDRESS: 1739 FOREST DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES — Middle F. — Last ROBERTS

4. DATE OF DEATH: Month 11 — Day 4 — Year 1957

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4/10/1889

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CIVIL SERVICE
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't.

11. BIRTHPLACE (State or foreign country): OHIO

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: JAMES F. ROBERTS

14. MOTHER'S MAIDEN NAME: SARAH RINEHART

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES
(If yes, give war or dates of service): WWI + II

16. SOCIAL SECURITY NO.:

17. INFORMANT: DOROTHY SKIPPER — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Disease — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

4343

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour 2:30 p.m. — Month, Day, Year 11-4-57
20d. INJURY OCCURRED: White at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f. (City or town) Annapolis (County) A.A. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: [signature] M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 11-4-57

EXAMINER'S NAME (Type): E. Lohrmann

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 11/7/57
22c. NAME OF CEMETERY OR CREMATORY: NAVAL ACADEMY
22d. LOCATION (City, town, or county) ANNAPOLIS (State) MD

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor & Sons — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: 11/6/57
24b. REGISTRAR'S SIGNATURE: [signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 . 11472

11464 CERTIFICATE OF DEATH

Reg. Dist. No. .....

THIS IS A PERMANENT RECORD.
PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.
Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.
THIS CERTIFICATE MUST BE FILED WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER DEATH.

1. NAME OF DECEASED (Type or Print): GEORGE M. SAUER

2. DATE OF DEATH: II/3/57

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Anne Arundel County Curtis Creek
c. Length of stay in Baltimore: Yrs. ... Mos. ... Days ...

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: A.A.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): Curtis Creek

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	W	II/II/74	82		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Operator	B.T.C.	Md.	

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Family - Same	

ML CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

4221
(A) Arteriosclerotic C.V. disease
DUE TO
ANTECEDENT CAUSES
(B) .....
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C) .....

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. .....

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20. AUTOPSY?
			YES ☐ NO ☐

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I certify that (I) (~~this hospital~~) attended the deceased from April 19 57 to Oct 31 19 57, that (I) (~~we~~) last saw the deceased alive on Oct 31 19 57, and that death occurred at 6 A m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Sidney R. Richards M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐	4700 Pennsylvania Ave	11/4/57

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
B	II/7/57	Glen Haven	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
NOV 5 1957	Huntington Williams	McCully Funeral Homes	130 E. Fort Ave.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11465

CERTIFICATE OF DEATH

Reg. Dist. No. 11473

1. PLACE OF DEATH
a. COUNTY ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Annapolis
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SAVUS NURSING HOME

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE MD. — b. COUNTY A.A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL ANNAPOLIS XI
d. STREET ADDRESS R.F.D #3
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First JOANNA Middle G. Last SHECKELLS
4. DATE OF DEATH Month 11 Day 28 Year 1957
5. SEX F
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 9-26-1903
9. AGE (In years last birthday) 54 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME
10b. KIND OF BUSINESS OR INDUSTRY HOME
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME GEORGE GARNER
14. MOTHER'S MAIDEN NAME JOANNA ROCKHOLD
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO.
17. INFORMANT FLOYD W. SHECKELLS Address #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 18 hr.
443X
DUE TO (b) Hypertension Arteriosclerosis CVD — 3 yr.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6-30-, 1954, to 11-28-, 1957, that I last saw the deceased alive on 11-27-57, 19___, and that death occurred at 2:35 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE Frank M Shipley M.D. — ADDRESS (Street, city or town, state) 63 College Ave — DATE SIGNED 11-29-57
PHYSICIAN'S NAME (Type) Frank M Shipley — Annapolis Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 12-1-57
22c. NAME OF CEMETERY OR CREMATORY SALEM CEM.
22d. LOCATION (City, town, or county) ANNAPOLIS (State) MD.
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor & Sons — ADDRESS Annapolis, Md.
24a. REC'D BY REGISTRAR DATE 12/2/57
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11412

CERTIFICATE OF DEATH

11474

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY Anne Arundel County MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
c. LENGTH OF STAY IN 1b 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel Gen Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md.
b. COUNTY A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Box 321. Pasadena Md. x2
d. STREET ADDRESS Faustrop. Manor
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Jennie Middle Margaret Last Shepard

4. DATE OF DEATH Month Nov. Day 25 Year 1957

5. SEX F

6. COLOR OR RACE W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Jan 30, 1907

9. AGE (In years last birthday) 50 yrs.

IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Baltimore

12. CITIZEN OF WHAT COUNTRY? U S.

13. FATHER'S NAME John Allen Brennan

14. MOTHER'S MAIDEN NAME Molly White

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO.

17. INFORMANT Address Husband Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyperpyrexia — INTERVAL BETWEEN ONSET AND DEATH 6 hrs

443x

DUE TO (b) Cerebral hemorrhage — 2

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) Hypertensive C. V. disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1956, 19____, to Nov 25, 1957 that I lost saw the deceased alive on Nov 24, 1957, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Robert R. Hahn M.D. ADDRESS (Street, city or town, state) Severna Park Md DATE SIGNED 11-25-57

PHYSICIAN'S NAME (Type) Robert R. HAHN Severna Park Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

22b. DATE THEREOF Nov. 29, 1957

22c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem Pk

22d. LOCATION (City, town, or county) (State) Glen Burnie Md

23. FUNERAL DIRECTOR'S SIGNATURE George J. Rowe ADDRESS 4001 Ritchie Hwy (25)

24a. REC'D BY REGISTRAR DATE 12/2/57

24b. REGISTRAR'S SIGNATURE Thos. J. Trench

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11475

11466 CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH
a. COUNTY: A. A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bristol
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XO Bristol
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Sarah Middle Ida Last Simmons

4. DATE OF DEATH: Month November Day 1 Year 1957

5. SEX: F

6. COLOR OR RACE: C

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct 14.

9. AGE (In years last birthday): 44 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Richard Sharps

14. MOTHER'S MAIDEN NAME: Frances Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Richard Simmons Bristol, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 5 mn

416X

DUE TO (b): Rheumatic C V Disease — 15 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1948, to 1 Nov, 1957, that I last saw the deceased alive on 31 Oct, 1957, and that death occurred at 5 35 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R R Dasser M.D. ADDRESS (Street, city or town, state): Upper Marlboro, Md DATE SIGNED: 1 Nov 57

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: Nov 4-57

22c. NAME OF CEMETERY OR CREMATORY: Mount

22d. LOCATION (City, town, or county) (State): Bristol A. A. Md

23. FUNERAL DIRECTOR'S SIGNATURE: P. J. Sewell ADDRESS: Prince Fred, Md

24a. REC'D BY REGISTRAR DATE: 11-5-57

24b. REGISTRAR'S SIGNATURE: A. W. Ward

A. W. Edwards

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11467 (Reg. Dist. No.) 11476 58

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville, Md.
c. LENGTH OF STAY IN 1b: 12ys,4mo,27da.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Springs, Md. 15X2.2
d. STREET ADDRESS: Route 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frances; Middle: ; Last: Smith

4. DATE OF DEATH: Month: 11; Day: 10; Year: 19 57

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3/3/16

9. AGE (In years last birthday): 41 yrs.
IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: ———

11. BIRTHPLACE (State or foreign country): ———

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Willie Smith

14. MOTHER'S MAIDEN NAME: Leona Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ——— (If yes, give war or dates of service): ———

16. SOCIAL SECURITY NO.: ———

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonitis — 593X — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Acute Renal Failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Spinal Tumor?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Psychosis with Mental Deficiency

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): ———

20c. TIME OF INJURY: Hour o. m. p. m. ——— Month, Day, Year ——— 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ———

20f. (City or town) (County) (State): ———

21. I certify that I attended the deceased from June 14, 1945, to November 10, 1957 that I last saw the deceased alive on November 10, 1957, and that death occurred at 8:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D. — ADDRESS (Street, city or town, state): Crownsville, Md. — DATE SIGNED: 11/12/57

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D. — Crownsville State Hospital, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Nov 16/57 — 22c. NAME OF CEMETERY OR CREMATORY: Good Hope — 22d. LOCATION (City, town, or county) (State): Colesville Md

23. FUNERAL DIRECTOR'S SIGNATURE: Robert L Snowden — ADDRESS: Rockville

24a. REC'D BY REGISTRAR — DATE: NOV 18 1957 — 24b. REGISTRAR'S SIGNATURE: A. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

RECEIVED

NOV 18 1957

BUREAU V. S.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13,14 FilmC223 12-12-57 et

CERTIFICATE OF DEATH

11468 — 11477 21 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: a a — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Drury
c. LENGTH OF STAY IN 1b: /
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: /

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: a a
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Drury X2
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First Charles Middle T Last Spriggs

4. DATE OF DEATH: Month November Day 20 Year 1957.

5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6/29/03
9. AGE (In years last birthday): 54 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LaborER-FarmeR
10b. KIND OF BUSINESS OR INDUSTRY: Tobacco
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas Spriggs
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Eva T Spriggs Address: Drury, Lothian R.D. No. 6.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral vascular accident
331X
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b): arteriosclerosis
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from not at all 19____, to ____ 19____, that I last saw the deceased alive on ____ 19____, and that death occurred at 12:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Emily H. Wilson M.D. ADDRESS (Street, city or town, state): Lothian, Md. DATE SIGNED: 11/20/57
acting coroner.
PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/24/57
22c. NAME OF CEMETERY OR CREMATORY: MOSES
22d. LOCATION (City, town, or county) (State): DRURY MD

23. FUNERAL DIRECTOR'S SIGNATURE: Bernard Hardesty ADDRESS: Galesville Md
24a. REC'D BY REGISTRAR DATE: DEC 2 1957
24b. REGISTRAR'S SIGNATURE: Mrs. J. French

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11469 — Reg. Dist. No. 11478

1. PLACE OF DEATH
a. COUNTY: A. A. Co — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
c. LENGTH OF STAY IN 1b: 1½ yrs
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION): #15 Sanders Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: W. Va — b. COUNTY: Mineral Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Piedmont, W. Virginia
d. STREET ADDRESS: #4 Green St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Thomas — Middle: Porter — Last: Swann
4. DATE OF DEATH: Month: 11 — Day: 14 — Year: 1957
5. SEX: M.
6. COLOR OR RACE: Wh.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 1880-12-14
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Coal miner - ret.
10b. KIND OF BUSINESS OR INDUSTRY: Coal
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? ✓

13. FATHER'S NAME: Thomas Swann
14. MOTHER'S MAIDEN NAME: Mary Fitzwaters
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 236-03-3917
17. INFORMANT: Family — Address: 15 Sanders Rd. Pasadena Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Cardiac Collapse — INTERVAL BETWEEN ONSET AND DEATH: 1 da
DUE TO
(b): CA of Rectum & Metastasis — 5 yr
DUE TO
(c): —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
154X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. ft. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4/25, 19—, to 11/14, 1957, that I last saw the deceased alive on 11/14, 1957, and that death occurred at 6 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Joseph G Lawkaitis M.D. — ADDRESS (Street, city or town, state): 679 Washington Blvd Balto Md — DATE SIGNED: —
PHYSICIAN'S NAME (Type): JOSEPH G. LAWKAITIS MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-18-57
22c. NAME OF CEMETERY OR CREMATORY: Phylos
22d. LOCATION (City, town, or county) (State): Watenport Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: McCully Funeral Homes — ADDRESS: Balto. Md.
24a. REC'D BY REGISTRAR DATE: NOV 21 1957
24b. REGISTRAR'S SIGNATURE: L. J. Deally

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11479

11470

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH
a. COUNTY: Anne Arundel Co MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie.
c. LENGTH OF STAY IN 1b: all his life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Box 56 B - Route 1 -
b. COUNTY: Glen Burnie. A.A. Co
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Glen Burnie.
d. STREET ADDRESS: Crain Highway -
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Grace Middle Lillian Last Tepper.

4. DATE OF DEATH: Month November Day 22. Year 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct 4, 1897
9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife.
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Balt. Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ~~Phillip Emge~~ Phillip Emge
14. MOTHER'S MAIDEN NAME: Sophia Stumler.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Paul Tepper. Address: Same as 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 years
DUE TO
096.9
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Acute Virus Infection - — 5 days
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1947, to Nov 22, 1957, that I last saw the deceased alive on November 21, 1957, and that death occurred at 5: a. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James S. Billingslea M.D.
ADDRESS (Street, city or town, state): 108 Central Av Glen Burnie Md
DATE SIGNED: Nov 22, 1957
PHYSICIAN'S NAME (Type): James S. Billingslea M.D

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/25/57
22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial
22d. LOCATION (City, town, or county) (State): Glen Burnie, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: James E. Kirkley
ADDRESS: Hopping and Kirkley, Glen Burnie, Md.
24a. REC'D BY REGISTRAR DATE: NOV 25 1957
24b. REGISTRAR'S SIGNATURE: L. J. Dellaz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11480

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11413

Reg. Dist. No. 7

1. PLACE OF DEATH — a. COUNTY: A. A. County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: A. A. County
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): xo Mayo
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Herbert — Middle: M. — Last: Thomas

4. DATE OF DEATH: Month: 11 — Day: 8 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-1-1929

9. AGE (In years last birthday): 28 yrs.

IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: ?

11. BIRTHPLACE (State or foreign country): Mayo Md

12. CITIZEN OF WHAT COUNTRY? U-S-A.

13. FATHER'S NAME: Marshall Thomas

14. MOTHER'S MAIDEN NAME: Sadie Cook

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): 1-5-1951-12-19-56

16. SOCIAL SECURITY NO.: 217-24-9935

17. INFORMANT: Marshall Thomas — Address: Mayo Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Compound Fracture Skull — INTERVAL BETWEEN ONSET AND DEATH: Instan

825X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Auto accident

20c. TIME OF INJURY — Hour: P.M. — Month, Day, Year: 11-5-57

20d. INJURY OCCURRED — While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway

20f. (City or town) (County) (State): Mayo A.A.Co Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.

EXAMINER'S NAME (Type): F. Linhardt

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 11-8-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 11-11-1957 — 22c. NAME OF CEMETERY OR CREMATORY: Mayo — 22d. LOCATION (City, town, or county) (State): Mayo Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese — ADDRESS: 108 Wash St Annapolis Md

24a. REC'D BY REGISTRAR: NOV 12 1957

24b. REGISTRAR'S SIGNATURE: [signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bond copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11481

CERTIFICATE OF DEATH

11471

Reg. Dist. No. 24

1. PLACE OF DEATH

COUNTY Anne Arundel — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS 1221 Wilson Road

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland — COUNTY Anne Arundel

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

STREET ADDRESS (If rural give location) 1221 Wilson Road-Glen Burnie, Md.

3. NAME OF DECEASED (Type or Print) (First) NOAH (Middle) OLIVER (Last) TRACY

4. DATE OF DEATH (Month) NOVEMBER (Day) 8 (Year) 19 57

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Widowed	Oct. 11, 1878	79 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Rate Clerk	Associated Transport	Baltimore, Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James Tracy	Mary Stevens

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No	Yes	Mr. Kenneth O. Tracy-405 3rd Ave. S.W. Glen Burnie, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

180X IMMEDIATE CAUSE (A) Malignant Tumor of Kidney — INTERVAL BETWEEN ONSET AND DEATH 8 mo

ANTECEDENT CAUSE(S) DUE TO (B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 1950, 19..., to 11/8, 19 57, that I last saw the deceased alive on 11/3, 19 57, and that death occurred at 7 P.M., from the causes and on the date stated above.

SIGNATURE	ADDRESS (Street, city, town, state)	DATE SIGNED
Bryant L. Jones M.D.	104 Crain Hwy S Glen Burnie	11/8/57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	11/11/57	Lorraine Park Cemetery	Baltimore, Maryland

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
NOV 12 1957	L. J. Dellay	Wm. D. Tuckner	Lone Mount Palms

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11414

CERTIFICATE OF DEATH

11482

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b: 7 Years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: USNH ANNAPOLIS, MD.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 ANNAPOLIS
d. STREET ADDRESS: 77 Shipwright Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CLAIRE — Middle O'NEILL — Last VOGEL

4. DATE OF DEATH: Month NOV — Day 16 — Year 19 57

5. SEX: Female

6. COLOR OR RACE: Cau

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 15 June 1945

9. AGE (In years last birthday): 12 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: - - -

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: RAYMOND WILLIAM VOGEL

14. MOTHER'S MAIDEN NAME: CLAIRE PATRICIA O'NEILL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): - - - (If yes, give war or dates of service): - - -

16. SOCIAL SECURITY NO.: - - -

17. INFORMANT: Address: USNH ANNAPOLIS, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): DIFFUSE BRONCHOPNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH

491X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) STAPHYLOCOCCUS AUREUS — 5 Days

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 15 Nov, 19 57, to 16 Nov, 19 57, that I last saw the deceased alive on 16 Nov, 19 57, and that death occurred at 3:10A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: for Robert Bunch Lt MC USNR — M.D. — ADDRESS (Street, city or town, state): USNH ANNAPOLIS, MD. — DATE SIGNED: 11-16-57

PHYSICIAN'S NAME (Type): B. A. WEISS LT MC USNR

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11-19-57

22c. NAME OF CEMETERY OR CREMATORY: Naval Academy Cemetery

22d. LOCATION (City, town, or county) (State): Annapolis, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Hopping Funeral Home — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: NOV 19 1957

24b. REGISTRAR'S SIGNATURE: Wm. J. Stench

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11472 — Reg. Dist. No. 11483

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater
c. LENGTH OF STAY IN 1b: 43 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 5 Puddington Drive(Home)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Georgia
b. COUNTY: Muscogee
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Midland
d. STREET ADDRESS: Route 1 Old Macon Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First James — Middle Jefferson — Last Wadkins

4. DATE OF DEATH: Month Nov — Day 4 — Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept 1st, 1892

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Textile Worker

10b. KIND OF BUSINESS OR INDUSTRY: Textile

11. BIRTHPLACE (State or foreign country): Alabama

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Franklin Wadkins

14. MOTHER'S MAIDEN NAME: Florence Bennett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 418-05-2104

17. INFORMANT: Maude B. Wadkins(wife), Address Edgewater

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pneumonia, Hypostatic, Terminal. — INTERVAL BETWEEN ONSET AND DEATH: 4 days

332 x

DUE TO (b): Thrombosis, Cerebral. — 1 week.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Hypertensive, Arteriosclerotic disease. — 5 years.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Brain Syndrome due to Cerebral Arteriosclerosis.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 22nd, 1957, to Nov. 4th, 1957, that I last saw the deceased alive on Nov 4th., 1957, and that death occurred at 1.05 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D. — ADDRESS (Street, city or town, state): State Hospital, Crownsville, Md. — DATE SIGNED: Nov 4th., 57

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal-Burial — 22b. DATE THEREOF: November 5, 57 — 22c. NAME OF CEMETERY OR CREMATORY: Lanett Cemetery — 22d. LOCATION (City, town, or county) (State): Lanett, Alabama

23. FUNERAL DIRECTOR'S SIGNATURE: [signature] — ADDRESS: HOPPING FUNERAL HOME, Annapolis, Maryland

24a. REC'D BY REGISTRAR DATE: NOV 7 '57 — 24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page 3 [illegible] be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 [illegible] 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11473 **CERTIFICATE OF DEATH** 11484

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: a a — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mayo
c. LENGTH OF STAY IN 1b: 39 yrs
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 MAYO
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First OLLIE Middle ALBERT Lost WHEATLEY

4. DATE OF DEATH: Month Nov Day 12 Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6/29/88

9. AGE (In years last birthday): 68 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): carpenter

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Seaford, Delaware

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Charles Wheatley

14. MOTHER'S MAIDEN NAME: ELIZABETH Tulle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 215-12-4368

17. INFORMANT: Laura Wheatley Address: Mayo and

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemmorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.
331X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): gen. arteriosclerosis
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 19 49, to Nov. 12, 19 57 that I last saw the deceased alive an Nov. 5, 19 57, and that death occurred at 1:50 PM from the causes and an the date stated abave.

ACTUAL SIGNATURE: S. Borssuck M.D. ADDRESS (Street, city or town, state): Amos Garrett Blvd., DATE SIGNED: 11/13/57

PHYSICIAN'S NAME (Typo): S. Borssuck, M.D. Annapolis, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 11/16/57

22c. NAME OF CEMETERY OR CREMATORY: Mayo Memorial

22d. LOCATION (City, town, or county) (State): Mayo Md

23. FUNERAL DIRECTOR'S SIGNATURE: Burrell Hardesty ADDRESS: Galesville Md

24a. REC'D BY REGISTRAR DATE 11/15/57

24b. REGISTRAR'S SIGNATURE: C. O'Connell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11474 — 11485 — Reg. Dist. No. 25

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Same — b. COUNTY: Same	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn 25 — c. LENGTH OF STAY IN 1b: 4 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Same 50	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 411 Cresswell Rd.	d. STREET ADDRESS: Same 1	e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): George (First) George Rutherford (Middle) Wicklein (Last)	4. DATE OF DEATH: Month November Day 16 Year 19 57	
5. SEX: M.	6. COLOR OR RACE: W	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5/4/92	9. AGE (In years last birthday): 65 yrs.	IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Blacksmith	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Baltimore, Md. — 12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: George R. Wicklein	14. MOTHER'S MAIDEN NAME: Susanne Hiss	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 215-01-2390	17. INFORMANT: Mrs. Hazel Wicklein (wife) — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hypertensive Cardio Vascular Diseases — INTERVAL BETWEEN ONSET AND DEATH: Over 2 years.

443X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 19 56 to 11/16/57, 19 ____, that I last saw the deceased alive on 11/8/57, 19 ____, and that death occurred at 12.45P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Gustave H Faubert M.D. — ADDRESS (Street, city or town, state): Glen Burnie, Md. — DATE SIGNED: 11/17/57

PHYSICIAN'S NAME (Type): Gustave H. Faubert, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial	22b. DATE THEREOF: 11-20-57	22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State): Baltimore 25, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: McCully Funeral Home, 130 E. Fort Ave., Balto. Md.	24a. REC'D BY REGISTRAR — DATE: NOV 20 1957	24b. REGISTRAR'S SIGNATURE: John Hudson	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11475 Item 9 FilmG223 12-12-57 et

11486

Reg. Dist. No. 27

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTPORT
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland b. COUNTY A. A. County
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harwood Maryland x2
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First HARRISON Middle Last Williams
4. DATE OF DEATH Month 11 Day 23 Year 1957
5. SEX Male
6. COLOR OR RACE Colored
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Approx.
9. AGE (In years last birthday) 52 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Thomas Williams
14. MOTHER'S MAIDEN NAME Alice Randall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 212-14-3381
17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Drowning
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found Floating in Severn River
20c. TIME OF INJURY Month, Day, Year Hour, a. m. UNKNOWN 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) River
20f. (City or town) EASTPORT (County) AA (State) MD

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE R S Fisher M.D.
CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED 11-24-57
EXAMINER'S NAME (Type) R. S. FISHER

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 11-27-57
22c. NAME OF CEMETERY OR CREMATORY Brewer Hill
22d. LOCATION (City, town, or county) (State) Annapolis A. A. Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE William R. Reese ADDRESS #108 Worth St Annapolis Md.
24a. REC'D BY REGISTRAR DATE 12/2/57
24b. REGISTRAR'S SIGNATURE Jm J Feaney

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11415

CERTIFICATE OF DEATH

11487

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Anne Arundel General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis #1
d. STREET ADDRESS: R. R. #1
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Shirley — Middle: Ann — Last: Woolford

4. DATE OF DEATH: Month: 11 — Day: 24 — Year: 1957

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-3-54

9. AGE (In years last birthday): 3 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: James Woolford

14. MOTHER'S MAIDEN NAME: Virginia Mae

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Mrs. H. Sillaman — Address: Annapolis

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Laryngo-Tracheitis — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.
474x
DUE TO
(b)
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO
(c) Laryngo-Tracheitis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11-24, 1957, to 11-24, 1957, that I last saw the deceased alive on 11-24, 1957, and that death occurred at 8:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Clayton Norton M.D. — ADDRESS (Street, city or town, state): 95 Cathedral St. — DATE SIGNED

PHYSICIAN'S NAME (Type): Clayton Norton Annapolis, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Nov 27-57

22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Cemetery

22d. LOCATION (City, town, or county) (State): Glen Burnie Anne Arundel Co Md

23. FUNERAL DIRECTOR'S SIGNATURE: Bernard A Fink — ADDRESS: Glen Burnie Md

24a. REC'D BY REGISTRAR DATE: DEC 2 1957

24b. REGISTRAR'S SIGNATURE: Wm. J. French

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55